



SESSIONS

Case Histories

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Contents

Introduction	1
Part 1: Foundation Year	2
The Hernandez Family	3
The Parker Family	6
The Logan Family	9
The Johnson Family	11
Part 2: Concentration Year	14
The Levy Family	15
The Bradley Family	17
The Petrakis Family	20
The Cortez Family	23
Appendix	26
Reflection Questions	27
The Hernandez Family	27
The Parker Family	28
The Logan Family	30
The Johnson Family	31
The Levy Family	32
The Bradley Family	33
The Petrakis Family	35
The Cortez Family	36
Trademarks and Disclaimers	38

Introduction

The following eight cases are based on the true experiences of social workers in the field, although names and other identifying circumstances have been changed. The narratives in this book, combined with filmed representations of scenes inspired by the cases, provide you an opportunity to use true-to-life cases as an experiential learning tool. Whereas some academic programs, professors, or instructors may offer an occasional glimpse into past social work experiences, this book and these cases weave through multiple courses in your foundation and concentration year. Like in true-to-life practice, you will follow these cases through a variety of circumstances, practice behaviors, and learning opportunities. This unique format for a social work program enables you to integrate and connect the expected learning outcomes for each course. Each case either explicitly or implicitly offers content on practice skills, research, human behavior theory, and policy. Further, you will see that each family's concerns can be addressed across all levels of practice, from micro to mezzo to macro.

Approach this book as a series of cases to which you have been assigned during your first professional experience in social work. We encourage you to use a critical eye to analyze the approaches provided. Remember that each practitioner has his or her own lens or perspective that guides his or her practice and these cases, written in the voices of each individual social worker, offer you authentic, varied perspectives. As you review and dissect these cases, consider your own lens and perspective as a future social worker.

The families described in these cases have been connected to social work services in myriad ways. Look closely at how each family member is introduced to the social worker and at the services and interventions that follow. Through reading these cases and then watching them come to life on video, you will see the skills used by social work practitioners. Carefully identify for yourself how the social worker engages, assesses, and intervenes with his or her client.

The social workers who provided these cases offer some of their own personal thoughts about these cases as a series of reflection questions. Use the answers to the questions, posed to the social workers as they wrote these stories, to gain additional insight into the decisions they made to address their clients' concerns. Reflect on the questions and answers as a way to consider whether you would have addressed the client or clients in the same manner.

Imagine your first day of practice, preparing for your first client meeting. On your desk is a folder with the last name of the client on the tab. You open the folder to find a case history for your client—perhaps it details family background, medical history, or an accounting of interactions with other agencies. This book is like that folder, preparing you for the client you will soon meet.

PART 1: FOUNDATION YEAR

The Hernandez Family

Juan Hernandez (27) and Elena Hernandez (25) are a married Latino couple who were referred to the New York City Administration for Children Services (ACS) for abuse allegations. They have an 8-year-old son, Juan Jr., and a 6-year-old son, Alberto. They were married 7 years ago, soon after Juan Jr. was born. Juan and Elena were both born in Puerto Rico and raised in Queens, New York. They rent a two-bedroom apartment in an apartment complex where they have lived for 7 years. Elena works as babysitter for a family that lives nearby, and Juan works at the airport in the baggage department. Overall, their physical health is good, although Elena was diagnosed with diabetes this past year and Juan has some lower back issues from loading and unloading bags. Both drink socially with friends and family. Juan goes out with friends on the weekends sometimes to “blow off steam,” having six to eight beers, and Elena drinks sparingly, only one or two drinks a month. Both deny any drug use at all. While they do not attend church regularly, both identify as being Catholic and observe all religious holidays. Juan was arrested once as a juvenile for petty theft, but that has been expunged from his file. Elena has no criminal history. They have a large support network of friends and family who live nearby, and both Elena’s and Juan’s parents live within blocks of their apartment and visit frequently. Juan and Elena both enjoy playing cards with family and friends on the weekends and taking the boys out to the park and beach near their home.

ACS was contacted by the school social worker from Juan Jr.’s school after he described a punishment his parents used when he talked back to them. He told her that his parents made him kneel for hours while holding two encyclopedias (one in each hand) and that this was a punishment used on multiple occasions. The ACS worker deemed this a credible concern and made a visit to the home. During the visit, the parents admitted to using this particular form of punishment with their children when they misbehaved. In turn, the social worker from ACS mandated the family to attend weekly family sessions and complete a parenting group at their local community mental health agency. In her report sent to the mental health agency, the ACS social worker indicated that the form of punishment used by the parents was deemed abusive and that the parents needed to learn new and appropriate parenting skills. She also suggested they receive education about child development because she believed they had unrealistic expectations of how children at their developmental stage should behave. This was a particular concern with Juan Sr., who repeatedly stated that if the boys listened, stayed quiet, and followed all of their rules they would not be punished. There was a sense from the ACS worker that Juan Sr. treated his sons, especially Juan Jr., as adults and not as children. This was exhibited, she believed, by a clear lack of patience and understanding on his part when the boys did not follow all of his directions perfectly or when they played in the home. She mandated family sessions along with the parenting classes to address these issues.

During the intake session, when I met the family for the first time, both Juan and Elena were clearly angry that they had been referred to parenting classes and family sessions. They both felt they had done nothing wrong, and they stated that they were only punishing their children as they were punished as children in Puerto Rico. They said that their parents made them hold heavy books or other objects as they kneeled and they both stressed that at times the consequences for not behaving had been much worse. Both Juan and Elena were “beaten” (their term) by their parents. Elena’s parents used a switch, and Juan’s parents used a belt. As a result, they feel they are actually quite lenient with their children, and they said they never hit them and they never would. Both stated that they love their children very much and struggle to give them a good life. They both stated that the boys are very active and don’t always follow the rules and the kneeling punishment is the only thing that works when they “don’t want to listen.”

They both admitted that they made the boys hold two large encyclopedias for up to two hours while kneeling when they did something wrong. They stated the boys are “hyperactive” and “need a lot of attention.” They said they punish Juan Jr. more often because he is particularly defiant and does not listen and also because he is older and should know better. They see him as a role model for his younger brother and feel he should take that responsibility to heart. His misbehavior indicates to them that he is not taking that duty seriously and therefore he should be punished, both to learn his lesson and to show his younger brother what could happen if he does not behave.

During the intake meeting, Juan Sr. stated several times that he puts in overtime any time he can because money is “tight.” He expressed great concern about having to attend the parenting classes and family sessions, as it would interfere with that overtime. Elena appeared anxious during the initial meeting and repeatedly asked if they were going to lose the boys. I told her I could not assure her that they would not, but I could assist her and her husband through this process by making sure we had a plan that satisfied the ACS worker’s requirements. I told them it

would be up to them to complete those plans successfully. I offered my support through this process and conveyed empathy around their response to the situation.

Together we discussed the plan for treatment, following the requirements of ACS; they would attend a 12-week Positive Parenting Program (PPP) along with weekly family sessions. In an effort to reduce some of the financial burden of attending multiple meetings at the agency, I offered to meet with the family either just before or immediately after the PPP so that they did not have to come to the agency more than once a week. They agreed that this would be helpful because they did not have money for multiple trips to the agency, although Juan Sr. stated that this would still affect his ability to work overtime on that day. I asked if they had any goals they wanted to work toward during our sessions. Initially they were reluctant to share anything, and then Elena suggested that a discussion on money management would be helpful. I told them I would be their primary contact at the agency—meeting with them for the family sessions and co-facilitating the PPP group with an intern. I explained my limitations around confidentiality, and they signed a form acknowledging that I was required to share information about our sessions with the ACS worker. I informed them that the PPP is an evidenced-based program and explained its meaning. I informed them that there is a pre- and post-test administered along with the program and specific guidelines about missed classes. They were informed that if they missed more than three classes, their participation would be deemed incomplete and they would not get their PPP certification.

Initially, when the couple attended parenting sessions and family sessions, Juan Sr. expressed feelings of anger and resentment for being mandated to attend services at the agency. Several times he either refused to participate by remaining quiet or spoke to the social worker and intern in a demeaning manner. He did this by questioning our ability to teach the PPP and the effectiveness of the program itself, wanting to know how this was going to make him a better parent. He also reiterated his belief that his form of discipline worked and that it was exactly what his family members used for years on him and his relatives. He asked, “If it worked for them, why can’t that form of punishment work for me and my children?” He emphasized that these were his children. He maintained throughout the sessions that he never hit his children and never would. Both he and Elena often talked about their love for their children and the devastation they would feel if they were ever taken away from them.

Treatment consisted of weekly parenting classes with the goal of teaching them effective and safe discipline skills (such as setting limits through the use of time-out and taking away privileges). Further, the classes emphasized the importance of recognizing age-appropriate behavior. We spent sessions reviewing child development techniques to help boost their children’s self-esteem and sense of confidence. We also talked about managing one’s frustration (such as when to take a break when angry) and helping their children to do the same.

Family sessions were built around helping the family members express themselves in a safe environment. The parents and the children were asked to talk about how they felt about each other and the reason they were mandated to treatment. They were asked to share how they felt while at home interacting with one another. I thought it was of particular importance to have them talk about their feelings related to the call to ACS, as I was unsure how Juan Sr. felt about Juan Jr.’s report to the social worker. It was necessary to assist them with processing this situation so that there were no residual negative feelings between father and son. I asked them to role-play—having each member act like another member of the household. This was very effective in helping Juan Sr. see how his boys view him and his behavior toward them when he comes home from work. As a result of this exercise, he verbalized his newfound clarity around how the boys have been seeing him as a very angry and negative father.

I also used sessions to explore the parents’ backgrounds. Using a genogram, we identified patterns among their family members that have continued through generations. These patterns included the use of discipline to maintain order in the home and the potentially unrealistic expectations the elders had for their children and grandchildren. Elena stated that she was treated like an adult and had the responsibilities of a person much older than herself while she was still very young. Juan Sr. said he felt responsible for bringing money into the home at an early age. He was forced by his parents to get working papers as soon as he turned 14. His paychecks were then taken by his parents each week and used to pay for groceries and other bills. He expressed anger at his parents for encouraging him to drop out of high school so that he could get more than one job to help out with the finances.

Other sessions focused on the burden they felt related to their finances and how that burden might be felt by the boys, just as Juan Sr. might have felt growing up. In one session, Juan Jr. expressed his fears of being evicted and the lights being turned off, because his father often talked of not having money for bills. Both boys expressed sadness over the amount of time their father spent at work and stressed their desire to do more things with him at night and on the weekends. Both parents stated they did not realize the boys understood their anxieties around

The Hernandez Family

Juan Hernandez: father, 27

Elena Hernandez: mother, 25

Juan Hernandez Jr.: son, 8

Alberto Hernandez: son, 6

paying bills and felt sad that they worried about these issues. We also took a couple of sessions to address money management. We worked together to create a budget and identify unnecessary expenses that might be eliminated.

It was clear that this was a family that loved each other very much. Juan Sr. and Elena were often affectionate with each other and their sons. Once the initial anger subsided, both Juan Sr. and Elena fully engaged in both the family sessions and the PPP. We assessed their progress monthly and highlighted that progress. I also was aware that it was important to learn about the Hernandez family history and culture in order to understand their perspective and emotions around the ACS referral. I asked them many questions about their beliefs, customs, and culture to learn about how they view parenthood, marriage roles, and children's behaviors. They were always open to these questions and seemed pleased that I asked about these things rather than assumed I knew the answers.

During the course of treatment they missed a total of four PPP classes. I received a call from Elena each time letting me know that Juan Sr. had to work overtime and they would miss the class. She was always apologetic and would tell me she would like to know what they missed in the class so that she could review it on her own. During a call after the fourth missed parenting class, I reminded Elena that in order to obtain the certificate of completion, they were expected to attend a minimum of nine classes. By missing this last class, I explained, they were not going to get the certificate. Elena expressed fear about this and asked if there was any way they could still receive it. She explained that they only had one car and that she had to miss the classes when Juan Sr. could not go because she had no way of getting to the agency on her own. I told her that I did not have the authority to change the rules around the number of classes missed and that I understood how disappointed she was to hear they would not get the certificate. When I told her I had to call the ACS worker and let her know, Elena got very quiet and started to cry. I spoke with her for a while, and we talked about the possible repercussions.

I met with my supervisor and informed her of what had occurred. I knew I had to tell the ACS worker that they would not receive the certificate of completion this round, and I felt bad for the situation Juan Sr. and Elena and their boys were now in. I had been meeting with them for family sessions and parenting classes for almost three months by this point and had built a strong rapport. I feared that once I called the ACS worker, that rapport would be broken and they would no longer want to work with me. I saw them as loving and caring parents who were trying the best they could to provide for their family. They had been making progress, particularly Juan Sr., and I did not want their work to be in vain.

I also questioned whether the parenting and family sessions were really necessary for their situation. I felt there was a lack of cultural competence on the part of the ACS worker—she had made some rather judgmental and insensitive comments on the phone to me during the referral. I wondered if there was a rush to judgment on her part because their form of discipline was not commonly used in the United States. In my own professional opinion, some time-limited education on parenting and child development would have sufficed, as opposed to the 3-month parenting program and family sessions.

My supervisor and I also discussed the cultural competence at the agency and the fact that the class schedule may not fit a working family's life. We discussed bringing this situation to a staff meeting to strategize and see if we had the resources to offer the PPP multiple times during the week, perhaps allowing clients to make up a class on a day other than their original class day.

I met with Elena and Juan Sr. and let them know I had to contact the ACS worker about the missed classes. I explained that this was something I had to do by law. They told me they understood, although another round of parenting classes would be a financial burden and they had already struggled to attend the current round of classes each week. I validated their concerns and told them we were going to look at offering the program more than once a week. I also told them that when I spoke to the ACS worker, I would also highlight their progress in family and parenting sessions.

I called the ACS worker and told her all the positive progress the parents had made over the previous 3 months before letting her know that they had missed too many classes to obtain the PPP certificate. The ACS worker was pleased with the progress I described but said she would recommend to her supervisor that the parents take the PPP over again until a certificate was obtained. She would wait to hear what her supervisor's decision was on this matter. She said that family sessions could end at this point. In the end, the supervisor decided the parents needed to come back to the agency and just make up the four classes they missed. Elena and Juan Sr. were able to complete this requirement and received their certificate, and the ACS case was closed. They later returned on their own for a financial literacy class newly offered at the agency free of charge.

Key to Acronyms

ACS: Administration for
Children Services

PPP: Positive Parenting Program

The Parker Family

Sara is a 72-year-old widowed Caucasian female who lives in a two-bedroom apartment with her 48-year-old daughter, Stephanie, and six cats. Sara and her daughter have lived together for the past 10 years, since Stephanie returned home after a failed relationship and was unable to live independently. Stephanie has a diagnosis of bipolar disorder, and her overall physical health is good. Stephanie has no history of treatment for alcohol or substance abuse; during her teens she drank and smoked marijuana but no longer uses these substances. When she was 16 years old, Stephanie was hospitalized after her first bipolar episode. She had attempted suicide by swallowing a handful of Tylenol® and drinking half a bottle of vodka after her first boyfriend broke up with her. She has been hospitalized three times in the past 4 years when she stopped taking her medications and experienced suicidal ideation. Stephanie's current medications are Lithium, Paxil®, Abilify®, and Klonopin®.

Stephanie recently had a brief hospitalization as a result of depressive symptoms. She attends a mental health drop-in center twice a week to socialize with friends and receives outpatient psychiatric treatment at a local mental health clinic for medication management and weekly therapy. She is maintaining a part-time job at a local supermarket where she bags groceries and is currently being trained to become a cashier. Stephanie currently has active Medicare and receives Social Security Disability (SSD).

Sara has recently been hospitalized for depression and has some physical issues. She has documented high blood pressure and hyperthyroidism, she is slightly underweight, and she is displaying signs of dementia. Sara has no history of alcohol or substance abuse. Her current medications are Lexapro® and Zyprexa®. Sara has Medicare and receives Social Security benefits and a small pension. She attends a day treatment program for seniors that is affiliated with a local hospital in her neighborhood. Sara attends the program 3 days a week from 9:00 a.m. to 2:00 p.m., and van service is provided free of charge.

A telephone call was made to Adult Protective Services (APS) by the senior day treatment social worker when Sara presented with increased confusion, poor attention to daily living skills, and statements made about Stephanie's behavior. Sara told the social worker at the senior day treatment program that, "My daughter is very argumentative and is throwing all of my things out." She reported, "We are fighting like cats and dogs; I'm afraid of her and of losing all my stuff."

During the home visit, the APS worker observed that the living room was very cluttered, but that the kitchen was fairly clean, with food in the refrigerator and cabinets. Despite the clutter, all of the doorways, including the front door, had clear egress. The family lives on the first floor of the apartment building and could exit the building without difficulty in case of emergency. The litter boxes were also fairly clean, and there was no sign of vermin in the home.

Upon questioning by the APS worker, Sara denied that she was afraid of her daughter or that her daughter had been physically abusive. In fact, the worker observed that Stephanie had a noticeable bruise on her forearm, which appeared defensive in nature. When asked about the bruise, Stephanie reported that she had gotten it when her mother tried to grab some items out of her arms that she was about to throw out. Stephanie admitted to throwing things out to clean up the apartment, telling the APS worker, "I'm tired of my mother's hoarding." Sara agreed with the description of the incident. Both Sara and Stephanie admitted to an increase in arguing, but denied physical violence. Sara stated, "I didn't mean to hurt Stephanie. I was just trying to get my things back."

The APS worker observed that Sara's appearance was unkempt and disheveled, but her overall hygiene was adequate (i.e., clean hair and clothes). Stephanie was neatly groomed with good hygiene. The APS worker determined that no one was in immediate danger to warrant removal from the home but that the family was in need of a referral for Intensive Case Management (ICM) services. It was clear there was some conflict in the home that had led to physical confrontations. Further, the house had hygiene issues, including trash and items stacked in the living room and Sara's room, which needed to be addressed. The APS worker indicated in her report that if not adequately addressed, the hoarding might continue to escalate and create an unsafe and unhygienic environment, thus leading to a possible eviction or recommendation for separation and relocation for both women.

As the ICM worker, I visited the family to assess the situation and the needs of the clients. Stephanie said she was very angry with her mother and sick of her compulsive shopping and hoarding. Stephanie complained that they did not have any visitors and she was ashamed to invite friends to the home due to the condition of the apartment. When I asked Sara if she saw a problem with so many items littering the apartment, Sara replied, "I need all of these things." Stephanie complained that when she tried to clean up and throw things out, her mother went

outside and brought it all back in again. We discussed the need to clean up the apartment and make it habitable for them to remain in their home, based on the recommendations of the APS worker. I also discussed possible housing alternatives, such as senior housing for Sara and a supportive apartment complex for Stephanie. Sara and Stephanie both stated they wanted to remain in their apartment together, although Stephanie questioned whether her mother would cooperate with cleaning up the apartment. Sara was adamant that she did not want to be removed from their apartment and would try to accept what needed to be done so they would not be forced to move.

Stephanie reported her mother is estranged from her younger sister, Jane, because of the hoarding. Stephanie also mentioned she was dissatisfied with her mother's psychiatric treatment and felt she was not getting the help she needed. She reported that her mother was very anxious and was having difficulty sleeping, staying up until all hours of the night, and buying items from a televised shopping network. Sara's psychiatrist had recently increased her Zyprexa prescription dosage to help reduce her agitation and possible bipolar disorder (as evidenced by the compulsive shopping), but Stephanie did not feel this had been helpful and actually wondered if it was contributing to her mother's confusion. I asked for permission to contact Jane and both of their outpatient treatment teams, and both requests were granted.

I immediately contacted Jane, who initially was uncooperative and stated she was unwilling to assist. Jane is married, with three children, and lives 3 hours away. At the beginning of our phone call, Jane said, "I've been through this before and I'm not helping this time." When I asked if I could at least keep in touch with her to keep her informed of the situation and any decisions that might need to be made, Jane agreed. After a few more minutes of discussion around my role and responsibilities, I was able to establish a bit of rapport with Jane. She then started to ask me questions and share some insight into what was going on in her mother and sister's home.

Jane informed me that she was very angry with her mother and had not brought her children to the apartment in years because of its condition. She said that her mother started compulsively shopping and hoarding when she and Stephanie were in high school, and while her father had tried to contain it as best he could, the apartment was always cluttered. She said this had been a source of conflict and embarrassment for her and Stephanie all of their lives. She said that after her father died of a heart attack, the hoarding got worse, and neither she nor Stephanie could control it. Jane also told me she felt her mother was responsible for Stephanie's relapses. Jane reported that Stephanie had been compliant with her medication and treatment in the past, and that up until a few years ago, had not been hospitalized for several years. Jane had told Stephanie in the past to move out.

Jane also told me that she "is angry with the mental health system." Sara had been recently hospitalized for depression, and Jane took pictures of the apartment to show the inpatient treatment team what her mother was going home to. Jane felt they did not treat the situation seriously because they discharged her mother back to the apartment. Stephanie had been hospitalized at the same time as her mother, but in a different hospital, and Jane had shown the pictures to her sister's treatment team as well. Initially the social worker recommended that Stephanie not return to the apartment because of the state of the home, but when that social worker was replaced with someone new, Stephanie was also sent back home.

When I inquired if there were any friends or family members who might be available and willing to assist in clearing out the apartment, Jane said her mother had few friends and was not affiliated with a church group or congregation. However, she acknowledged that there were two cousins who might help, and she offered to contact them and possibly help herself. She said that she would ask her husband to help as well, but she wanted assurance that her mother would cooperate. I explained that while I could not promise that her mother would cooperate completely, her mother had stated that she was willing to do whatever it took to keep living in her home. Jane seemed satisfied with this response and pleased with the plan.

I then arranged to meet with Sara and her psychiatrist to discuss her increased anxiety and confusion and the compulsive shopping. I requested a referral for neuropsychiatric testing to assess possible cognitive changes or decline in functioning. A test was scheduled, and it indicated some cognitive deficits, but at the end of testing, Sara told the psychologist who administered the tests she had stopped taking her medications for depression. It was determined Sara's depression and discontinuation of medication could have affected her test performance and it was recommended she be retested in 6 months. I suggested a referral to a geriatric psychiatrist for Sara, as she appeared to need more specialized treatment. Sara's psychologist was in agreement.

Because they had both stated that they did not want to be removed from their home, I worked with Sara and Stephanie as a team to address cleaning the apartment. All agreed that they would begin working together to clean the house for 1 hour a day until arrangements were made for additional help from family members. In an attempt

The Parker Family

Sara Parker: mother, 72

Stephanie Parker: daughter, 48

Jane Rodgers: daughter, 45

to alleviate Sara's anxiety around throwing out the items, I suggested using three bags for the initial cleanup: one bag was for items she could throw out, the second bag was for "maybes," and the third was for "not ready yet." I scheduled home visits at the designated cleanup time to provide support and encouragement and to intervene in disputes. I also contacted Sara's treatment team to inform them of the cleanup plans and suggested that Sara might need additional support and observation as it progressed. Jane notified me that her two cousins were willing to assist with the cleanup, make minor repairs, and paint the apartment. Jane offered to schedule a date that would be convenient for her and her cousins to come and help out.

We then discussed placement for at least some of the cats, because six seemed too many for a small apartment. Sara and Stephanie were at first adamant that they could not give up their cats, but with further discussion admitted it had become extremely difficult to manage caring for them all. They both eventually agreed to each keep their favorite cat and find homes for the other four. Sara and Stephanie made fliers and brought them to their respective treatment programs to hand out. Stephanie also brought fliers about the cats to her place of employment. Three of the four cats were adopted within a week.

During one home visit, Stephanie pulled me aside and said she had changed her mind—she did not want to continue to live with her mother. She requested that I complete a housing application for supportive housing stating, "I want to get on with my life." Stephanie had successfully completed cashier training, and the manager of the supermarket was pleased with her performance and was prepared to hire her as a part-time cashier soon. She expressed concern about how her mother would react to this decision and asked me for assistance telling her.

We all met together to discuss Stephanie's decision to apply for an apartment. Sara was initially upset and had some difficulty accepting this decision. Sara said she had fears about living alone, but when we discussed senior living alternatives, Sara was adamant she wanted to remain in her apartment. Sara said she had lived alone for a number of years after her husband died and felt she could adjust again. I offered to help her stay in her apartment and explore home care services and programs available that will meet her current needs to remain at home.

Key to Acronyms

APS: Adult Protective Services

ICM: Intensive Case Management
services

SSD: Social Security Disability

The Logan Family

Eboni Logan is a 16-year-old biracial African American/Caucasian female in 11th grade. She is an honors student, has been taking Advanced Placement courses, and runs track. Eboni plans to go to college and major in nursing. She is also active in choir and is a member of the National Honor Society and the student council. For the last 6 months, Eboni has been working 10 hours a week at a fast food restaurant. She recently passed her driver's test and has received her license.

Eboni states that she believes in God, but she and her mother do not belong to any organized religion. Her father attends a Catholic church regularly and takes Eboni with him on the weekends that she visits him.

Eboni does not smoke and denies any regular alcohol or drug usage. She does admit to occasionally drinking when she is at parties with her friends, but denies ever being drunk. There is no criminal history. She has had no major health problems.

Eboni has been dating Darian for the past 4 months. He is a 17-year-old African American male. According to Eboni, Darian is also on the track team and does well in school. He is a B student and would like to go to college, possibly for something computer related. Darian works at a grocery store 10–15 hours a week. He is healthy and has no criminal issues. Darian also denies smoking or regular alcohol or drug usage. He has been drunk a few times, but Eboni reports that he does not think it is a problem. Eboni and Darian became sexually active soon after they started dating, and they were using withdrawal for birth control.

Eboni's mother, Darlene, is 34 years old and also biracial African American/Caucasian. She works as an administrative assistant for a local manufacturing company. Eboni has lived with her mother and her maternal grandmother, May, from the time she was born. May is a 55-year-old African American woman who works as a paraprofessional in an elementary school. They still live in the same apartment where May raised Darlene.

Darlene met Eboni's father, Anthony, when she was 17, the summer before their senior year in high school. Anthony is 34 years old and Caucasian. They casually dated for about a month, and after they broke up, Darlene discovered she was pregnant and opted to keep the baby. Although they never married each other, Anthony has been married twice and divorced once. He has four other children in addition to Eboni. She visits her father and stepmother every other weekend. Anthony works as a mechanic and pays child support to Darlene.

Recently, Eboni took a pregnancy test and learned that she is 2 months pregnant. She actually did not know she was pregnant because her periods were not always consistent and she thought she had just skipped a couple of months. Eboni immediately told her best friend, Brandy, and then Darian about her pregnancy. He was shocked at first and suggested that it might be best to terminate. Darian has not told her explicitly to get an abortion, but he feels he cannot provide for her and the baby as he would like and thinks they should wait to have children. He eventually told her he would support her in any way he could, whatever she decides. Brandy encouraged Eboni to meet with the school social worker.

During our first meeting, Eboni told me that she had taken a pregnancy test the previous week and it was positive. At that moment, the only people who knew she was pregnant were her best friend and boyfriend. She had not told her parents and was not sure how to tell them. She was very scared about what they would say to her. We talked about how she could tell them and discussed various responses she might receive. Eboni agreed she would tell her parents over the weekend and see me the following Monday. During our meeting I asked her if she used contraception, and she told me that she used the withdrawal method.

Eboni met with me that following Monday, as planned, and she was very tearful. She had told her parents and grandmother over the weekend. Eboni shared that her mother and grandmother had become visibly upset when they learned of the pregnancy, and Darlene had yelled and called her a slut. Darlene told Eboni she wanted her to have a different life than she had had and told her she should have an abortion. May cried and held Eboni in her arms for a long time. When Eboni told her father, he was shocked and just kept shaking his head back and forth, not saying a word. Then he told her that she had to have this child because abortion was a sin. He offered to help her and suggested that she move in with him and her stepmother.

Darlene did not speak to Eboni for the rest of the weekend. Her grandmother said she was scheduling an appointment with the doctor to make sure she really was pregnant. Eboni was apprehensive about going to the doctor, so we discussed what the first appointment usually entails. I approached the topic of choices and decisions if it was confirmed that she was pregnant, and she said she had no idea what she would do.

Two days later, Eboni came to see me with the results of her doctor's appointment. The doctor confirmed the pregnancy, said her hormone levels were good, and placed her on prenatal vitamins. Eboni had had little morning sickness and no overt issues due to the pregnancy. Her grandmother went with her to the appointment, but her mother was still not speaking to her. Eboni was very upset about the situation with her mother. At one point she commented that parents are supposed to support their kids when they are in trouble and that she would never treat her daughter the way her mother was treating her. I offered to meet with Eboni and her mother to discuss the situation. Although apprehensive, Eboni gave me permission to call her mother and set up an appointment.

I left a message for Darlene to contact me about scheduling a meeting. She called back and agreed to meet with Eboni and me. When I informed Eboni of the scheduled meeting, she thanked me. She told me that she was going to spend the upcoming weekend with her father, and that she was apprehensive about how it would go. When I approached the topic of a decision about the pregnancy, she stated that she was not certain but was leaning in one direction, which she did not share with me. I suggested we get together before the meeting with her mother to discuss the weekend with her father.

At our next session, Eboni said she thought she knew what to do but after spending the weekend with her father was still confused. Eboni said her father went on at length about how God gives life, and that if she had an abortion, she would go to hell. Eboni was very scared. Anthony had taken her to church and told the priest that Eboni was pregnant and asked him to pray for her. Eboni said this made her feel uncomfortable.

When I met with Eboni and her mother, Darlene shared her thoughts about Eboni's pregnancy and her belief that she should have an abortion. She said she knows how hard it is to be a single mother and does not want this for Eboni. She believes that because Eboni is so young, she should do as she says. Eboni was very quiet during the session, and when asked what she thought, said she did not know. At the end of the session, nothing was resolved between Eboni and her mother.

When I met with Eboni the next day to process the session, she said that when they got home, she and her mother talked without any yelling. Her mother told Eboni she loved her and wanted what was best for her. May said she would support Eboni no matter what she decided and would help her if she kept the baby.

Eboni was concerned because she thought she was beginning to look pregnant and her morning sickness had gotten worse. I addressed her overall health, and she said that she wanted to sleep all the time, and that when she was not nauseated, all she did was eat. Eboni is taking her prenatal vitamins in case she decides to have the baby. Only a couple of her friends know about the pregnancy, and they had different thoughts on what they thought she should do. One friend even bought her a onesie. In addition, Eboni was concerned that her grades were being affected by the situation, possibly affecting her ability to attend college. She was also worried about how a pregnancy or baby would affect her chances of getting a track scholarship. In response to her many concerns, I educated her on stress-reduction methods.

Eboni asked me what I thought she should do, and I told her it was her decision to make for herself and that she should not let others tell her what to do. However, I also stated that it was important for her to know all the options. We discussed at length what it would mean for her to keep the baby versus terminating the pregnancy. I mentioned adoption and the possibility of an open adoption, but Eboni said she was not sure she could have a baby and then give it away. We discussed the pros and cons of adoption, and she stated she was even more confused. I reminded her that she did not have much time to make her decision if she was going to terminate. She said she wanted a few days to really consider all her options.

Eboni scheduled a time to meet with me. When she entered my office, she told me she had had a long talk with her mother and grandmother the night before about what she was going to do. She had also called her father and Darian and told them what she had decided. Eboni told me she knows she has made the right decision.

The Logan Family

May Logan: mother of Darlene, 55

Darlene Logan: mother, 34

Anthony Jennings: father, 34

Eboni Logan: daughter, 16

Darian: Eboni's boyfriend, 17

The Johnson Family

Talia is a 19-year-old heterosexual Caucasian female, who is a junior majoring in psychology and minoring in English. She has a GPA of 3.89 and has been on the dean's list several times over the last 3 years. She has written a couple of short articles for the university's newspaper on current events around campus and is active in her sorority, Kappa Delta. She works part time (10–15 hours a week) at an accessory store. Talia recently moved off campus to an apartment with two close friends from her sorority. She is physically active and runs approximately three miles a day. She also goes to the university's gym a couple of days a week for strength training. Talia does not use drugs, although she has smoked marijuana a few times in her life. She drinks a few times a week, often going out with friends one day during the week and then again on Friday and Saturday nights. When she is out with friends, Talia usually has about four to six drinks. She prefers to drink beer over hard liquor or wine, but will occasionally have a mixed drink.

Talia has no criminal history. She reports a history of anxiety in her family (on her mother's side), and on a few occasions has experienced heart palpitations, which her mother told her was due to nervousness. This happened only a handful of times in the past and usually when Talia was "very stressed out," so Talia had never felt the need to go to the doctor or talk to someone about it until now. Talia is currently not dating anyone. She was in a relationship for 1½ years, but it ended a few months ago. She had since been "hooking up" with a guy in one of her English classes, but does not feel it will turn into anything serious and has not seen him in several weeks.

Talia's parents, Erin (40) and Dave (43), and her siblings, Lila (16) and Nathan (14), live 2 hours away from the university. Erin works at a salon as a hairdresser, and Dave is retired military and works for a home security company. Erin is on a low-dose antidepressant for anxiety, something she has been treated for all of her life.

Talia came to see me at the Rape Counseling Center (RCC) on campus for services after she was sexually assaulted at a fraternity party 3 weeks prior. She told me she had thought she could handle her feelings after the assault, but she had since experienced a number of emotions and behaviors she could no longer ignore. She was not sleeping, she felt sad most days, she had stopped going out with friends, and she had been unable to concentrate on schoolwork. Talia stated that the most significant issues she had faced since the assault had been recurrent anxiety attacks.

Talia learned about the RCC when she went to the hospital after the sexual assault. She went to the hospital to request that a rape kit be completed and also requested the morning-after pill and the HIV prevention protocol (Post-Exposure Prophylaxis, or PEP). At that time, a nurse contacted me through the Sexual Assault Response Team (SART) to provide Talia with support and resources. I spent several hours with Talia at the hospital while she went through the examination process. Talia shared bits and pieces of the evening with me, although she said most of the night was a blur. She said a good-looking guy named Eric was flirting with her all night and bringing her drinks. She did not want to seem ungrateful and enjoyed his company, so she drank. She also mentioned that the drinks were made with hard liquor, something that tends to make her drunk faster than beer. She said that at one point she blacked out and has no idea what happened. She woke up naked in a room alone the next morning, and she went straight to the hospital. Once Talia was done at the hospital, I gave her the contact information for RCC. I encouraged her to call if she had any questions or needed to talk with someone.

During our first meeting at the RCC, I provided basic information about our services. I let her know that everything was confidential and that I wanted to help create a safe space for her to talk. I told her that we would move along at a pace that was comfortable for her and that this was her time and we could use it as she felt best. We talked briefly about her experience at the hospital, which she described as cold and demeaning. She told me several times how thankful she was that I had been there. She said one of the reasons she called the RCC was because she felt I supported and believed her. I used the opportunity to validate her feelings and remind her that I did, in fact, believe her and that the assault was not her fault.

We talked briefly about how Talia had been feeling over the last 3 weeks. She was very concerned about her classes because she had missed a couple of assignment deadlines and was fearful of failing. She told me several times this was not like her and she was normally a very good student. I told her I could contact the professors and advocate for extensions without disclosing the specific reason Talia was receiving counseling services and would need additional time to complete her assignments. Talia thanked me and agreed that would be best. I introduced the topic of safety and explained that she might possibly see Eric on campus, something that might cause

her emotional distress. We talked about strategies she could use to protect herself, and she agreed to walk with a friend while on campus for the time being. She also agreed she would avoid the gym where she had seen Eric before.

During our second meeting, Talia seemed very anxious. We talked about how she had been feeling over the last week, and she indicated she was still not sleeping well at night and that she was taking long naps during the day. She had missed days at work, something she had never done before, and was in jeopardy of losing her job. Talia reported experiencing several anxiety attacks as well.

She described the attack symptoms as feeling unable to breathe, accompanied by a swelling in her chest, and an overwhelming feeling that she was going to die. She said that this was happening several times a day, although mostly at night. I provided some education about trauma responses to sexual assault and the signs and symptoms of post-traumatic stress disorder (PTSD). We went over a workbook on trauma reactions to sexual assault and reviewed the signs and symptoms checklist, identifying several that she was experiencing. We practiced breathing exercises to use when she felt anxious, and she reported feeling better. I told her it was important to identify the triggers to her anxiety so that we could find out what exactly was causing her to be anxious in a given moment. I explained that while the assault itself had brought the attacks on, it would be helpful to see what specific things (such as memories, certain times of the day, particular smells, etc.) caused her to have anxiety attacks. I gave Talia an empty journal and asked her to record the times of the episodes over the next week as well as what happened right before them. She agreed.

We met over several sessions and continued to address Talia's anxiety symptoms and feelings of sadness. She told me she was unable to talk about what happened on the night of the rape because she felt ashamed. She said that it was too difficult for her to verbalize what happened and that the words coming out of her mouth would hurt too much. I reassured her that we would go at her pace and that she could talk about what happened when she felt comfortable. We practiced breathing and reviewed her journal log each week.

It had become clear that the evenings seemed to be the peak time for her anxiety, which I told her made sense as her assault had occurred at night. I described how sleep is often difficult for survivors of sexual assault because they fear having nightmares about what happened. She looked surprised and said she had not mentioned it, but she kept having dreams about Eric in which he was talking to her at the party. The dreams ended with him holding her hand and walking her away. She said she also thought about this during the day and could actually see it happening in her mind. We talked about the intrusive thoughts that often occur after trauma, and I tried to normalize her experience. I told her that often people try to avoid these intrusions, and I wondered if she felt she was doing anything to avoid them. She told me she had started taking a sleep aid at night. When I asked about her exercise habits, she said that right after the assault she had stopped running and going to the gym. We set a goal that she would run one to two times a week to help her with anxiety and sleeping. I also suggested that now would be a good time to start writing her feelings down because journaling is a very useful way to express feelings when it is difficult to verbalize them. Talia mentioned that she had decided not to go to the police about the sexual assault because she did not want to go through the process. I informed her that if she wanted to, she could address the assault in another way, by bringing it to the campus judicial system. She said she would think about this option.

During another session weeks later, Talia came in distraught. She said she had been feeling better overall since working on her breathing and doing the journaling, but that a few things had happened that were making her more and more anxious and that her attacks were increasing again. Talia said her parents were pushing her to drop out of school and to come home. She said they had been calling and texting her often, something she found annoying but understandable. They were very upset about what had happened, although they were more upset with her that she had waited for weeks to tell them about "it." Her father threatened to come and beat the guy up, and her mother cried. She avoided talking with them, but they had become relentless with the calls. Her mother had shown up with her sister unannounced the previous weekend and had treated Talia like she had a cold—making chicken soup and rubbing Talia's feet. The pressure from her parents was weighing on her and upsetting her. Talia was also distressed by a friend who kept pushing her to talk about what happened. When Talia finally relented, her friend asked her why she had gone upstairs with him. Talia said this made her feel terrible, and she started to cry. This friend also told her that Eric had heard she had gone to the hospital and was telling people that she had wanted to have sex. Eric had been telling people she was "all over him" and that she had taken her own pants off. This made Talia very angry and upset.

The Johnson Family

Erin Johnson: mother, 40

Dave Johnson: father, 43

Talia Johnson: daughter, 19

Lila Johnson: daughter, 16

Nathan Johnson: son, 14

We talked about how there are certain myths in society around sexual assault and that the victim is often blamed. We also talked about how the perpetrator often blames his or her victim to make himself or herself feel better. Talia said she has felt some sense of blame for what happened and that she should not have drunk so much. She started to cry. I gently reminded her that she was not at fault for Eric's actions, and her drinking was not an invitation to have sex. I reminded her that he should have seen how incapacitated she was and that she could not have consented to sex. Talia continued to cry. She clearly had a number of emotions she wanted to express but was having difficulty sharing them, so I offered her some clay and asked her to use it to mold representations of different areas in her life and how she felt about them. We spent the rest of the session talking about the shapes she made and how she felt. Toward the end of the session she told me she had decided to put in a complaint with the campus judicial system about the assault. She worried that Eric would assault another woman and she would feel responsible if she did not alert the university. I offered my support and told her I would be there for her through the process.

Key to Acronyms

HIV:	Human Immunodeficiency Virus Infection
PEP:	Post-Exposure Prophylaxis
PTSD:	Post-Traumatic Stress Disorder
RCC:	Rape Counseling Center
SART:	Sexual Assault Response Team

PART 2: CONCENTRATION YEAR

The Levy Family

Jake Levy (31) and Sheri (28) are a married Caucasian couple who live with their sons, Myles (10) and Levi (8), in a two-bedroom condominium in a middle-class neighborhood. Jake is an Iraq War veteran and employed as a human resources assistant for the military, and Sheri is a special education teacher in a local elementary school. Overall, Jake is physically fit, but an injury he sustained in combat sometimes limits his ability to use his left hand. Sheri is in good physical condition and has recently found out that she is pregnant with their third child.

As teenagers, Jake and Sheri used marijuana and drank. Neither uses marijuana now but they still drink. Sheri drinks socially and has one or two drinks over the weekend. Jake reports he has four to five drinks in the evenings during the week and eight to ten drinks on Saturdays and Sundays. Neither report having criminal histories.

Jake and Sheri identify as being Jewish and attend a local synagogue on major holidays. Jake's parents are deceased, and he has a sister who lives outside London. He and his sister are not very close but do talk twice a year. Sheri is an only child, and her mother lives in the area but offers little support. Her mother never approved of Sheri marrying Jake and thinks Sheri needs to deal with their problems on her own. The couple has some friends, but due to Jake's recent behaviors, they have slowly isolated themselves.

My first encounter with Jake was at an intake session at the Veterans Affairs Health Care Center (VA). During this meeting, Jake stated that he came to the VA for services because his wife had threatened to leave him if he did not get help. She was particularly concerned about his drinking and lack of involvement in his sons' lives. She told him his drinking had gotten out of control and was making him mean and distant. Jake had seen Dr. Zoe, a psychiatrist at the VA, who diagnosed him with post-traumatic stress disorder (PTSD). Dr. Zoe prescribed Paxil to help reduce his symptoms of anxiety and depression and suggested that he also begin counseling.

During the assessment, Jake said that since his return to civilian life 10 months ago he had experienced difficulty sleeping, heart palpitations, and moodiness. He told me that he and his wife had been fighting a lot and that he drank to take the edge off and to help him sleep. Jake admitted to drinking heavily nearly every day. He reported that he was not engaged with his sons at all and he kept to himself when he was at home. He spent his evenings on the couch drinking beer and watching TV or playing video games. When we discussed Jake's options for treatment he expressed fear of losing his job and his family if he did not get help. Jake worked in an office with civilians and military personnel and mostly got along with people in the office. Jake tended to keep to himself and said he sometimes felt pressured to be more communicative and social. He was also very worried that Sheri would leave him. He said he had never seen her so angry before and saw she was at her limit with him and his behaviors.

Based on the information Jake provided about his diagnosis and family concerns, we agreed that the best course of action would be for him to participate in weekly individual sessions with me and a weekly support group that was offered at the VA for Iraq veterans. I then offered a referral for couples counseling at the local mental health agency. I also printed out a list of local Alcoholics Anonymous (AA) meetings in his area if he decided he wanted to attend in order to address his drinking. He would continue to follow up with Dr. Zoe on a monthly basis to monitor the effectiveness of his medications.

The following session, I spent time explaining his diagnosis and the symptoms related to PTSD. Jake said that he did not really understand what PTSD was but thought it meant that a person who had it was "going crazy," which at times he thought was happening to him. He expressed concern that he would never feel "normal" again and said that when he drank alcohol, his symptoms and the intensity of his emotions eased. I explained to Jake that PTSD is a severe anxiety disorder that develops after a person has experienced an event that results in psychological trauma. The event may involve the threat or perceived threat of death to oneself or to someone else. I also explained that the disorder is characterized by re-experiencing the traumatic event, including the symptoms of increased arousal, and by the desire to avoid stimuli associated with the trauma. We talked about how his behaviors fit into this cycle of hyperarousal and avoidance, including his lack of sleep and irritability and the isolation and heavy drinking. He talked about always feeling "ready to go." He said he was exhausted from being always alert and looking for potential problems around him. He told me he always felt on edge and every sound seemed to startle him.

He shared that he often thinks about what happened "over there" but tries to push it out of his mind. It is the night that is the worst as he has terrible recurring nightmares of one particular event. He said he wakes up shaking and sweating most nights. He then said drinking was the one thing that seemed to give him a little relief. I gave him a handout on PTSD and reviewed the signs and symptoms. Jake seemed relieved to receive the information. I told

him that naming the issue or concern was often helpful in the healing process. During the first few sessions my goal was to help Jake feel safe and validate his feelings. We consistently assessed his feelings of safety, including any potential suicidal ideation. He was reluctant to attend AA at that time, so we began monitoring his drinking and his behaviors after several drinks.

Jake began his individual sessions practicing techniques I had shown him to help reduce his anxiety symptoms. We used deep breathing and guided meditation to help him remain calm and in the moment. We started to chart when he had intrusive thoughts about the war, potential triggers to his hyperarousal, and when he tried to dissociate or numb in reaction to these episodes.

Jake slowly began to share his experiences while in combat. I helped to gently guide him through the events that seemed to haunt him the most. I explained that telling one's story in effect helped him "own it," and in turn it would be integrated into his life on his terms. I told him that the act of telling his story can actually change the processing of the traumatic event in his brain. I was careful through this process not to push him into talking about events that seemed too traumatic for fear of re-traumatizing him. There were many sessions in which he started to share a specific event and then stopped mid-story and had to begin his relaxation exercises.

During this time he had also started participating in the veterans' support group. Jake reported that he was uneasy during the first couple of meetings because he did not know anyone, but that the other vets were supportive. He said it was helpful to hear from others who experienced the same feelings he had since he returned home. He said he no longer felt alone nor did he feel "crazy." Jake also shared that he had started attending AA meetings.

While I did not participate in the couples' sessions, Jake felt it was important that I hear about how these sessions were going. He told me the social worker at the local mental health clinic helped Sheri understand what he was going through by teaching her about PTSD.

The social worker explained how PTSD affected not only the individual, but the whole family and, in turn, the home environment. Jake said Sheri admitted that she did not understand what he was going through but that he was not the same person when he returned home from Iraq, and this scared her. Jake said Sheri seemed to be empathetic toward him and appeared to be relieved when the social worker explained his diagnosis.

Jake said he and Sheri worked together to address her main concerns. She felt he drank too much, was not communicating with her, was isolating himself from the family, and appeared to be depressed. She was particularly concerned about his lack of interaction with his sons and lack of interest in the current pregnancy. She worried that he would be uninvolved in caring for this new baby just as he was uninvolved with his boys.

Jake shared that in another couples' session, Sheri talked about wanting to be able to communicate with Jake without feeling that she was "nagging him" or fearful that she was making him withdraw. She said she avoided asking him things or talking to him for fear it would "set him off" and make him retreat to the basement on his own. As it stood, she did not think she could talk with Jake about her concerns. She told him she missed socializing with friends and having family outings and felt isolated. Jake said just keeping his intrusive thoughts at bay took all the energy he could muster, so making small talk with friends was not something he felt he could do right now. Sheri admitted that she did not know that socializing affected him that way. He said the social worker explained that for veterans with PTSD, oftentimes crowds, loud noises, and open spaces triggered intrusive memories and caused anxiety attacks. He said that he and Sheri had developed a plan that would improve their communication. He said they were going to slowly begin planning outings that he felt he could handle, and that they also agreed that if at any time he felt uncomfortable while out that they would leave.

Through individual, group, and couples sessions, Jake was able to address his trauma and his PTSD symptoms abated. He realized that drinking was being used as a way to avoid his feelings and attended AA meetings regularly. He has been able to maintain his sobriety and found a sponsor who is also a veteran. Sheri gave birth to a healthy baby boy, and Jake shared pictures of his son. He continues to attend group sessions and has become involved in some mentoring with young vets here at the VA. He feels strongly in giving back and has suggested that the VA begin a program that has been piloted in another state.

The Levy Family

Jake Levy: father, 31

Sheri Levy: mother, 28

Myles Levy: son, 10

Levi Levy: son, 8

Key to Acronyms

AA: Alcoholics Anonymous

PTSD: Post-Traumatic Stress
Disorder

VA: Veterans Affairs
Health Care Center

The Bradley Family

Tiffani Bradley is a 16-year-old heterosexual Caucasian female referred to me after being arrested for prostitution. I worked with Tiffani at Teens First, a brand new court-mandated teen counseling program for adolescent victims of sexual exploitation and human trafficking. At Teens First we provide a holistic range of services for our clients. Tiffani has been provided room and board in our residential treatment facility and will meet with a number of social workers to address her multiple needs and concerns.

Tiffani has been arrested three times for prostitution in the last 2 years. Right before her most recent charge, a new state policy was enacted to protect youth 16 years and younger from prosecution and jail time for prostitution. The Safe Harbor for Exploited Children Act allows the state to define Tiffani as a sexually exploited youth and therefore the state will not imprison her for prostitution. She was mandated to services at our agency, unlike her prior arrests when she had been sent to detention.

Tiffani had been living with a man she has identified as Donald since she was 14 years old. She had had limited contact with her family members and had not been attending school. She described Donald as her “husband” (although they were not married) and her only friend. She had contacted her sister, Diana, a few times over the previous 2 years and stated that she missed her very much. Donald had recently sold Tiffani to another pimp, “John T.” Tiffani reported that she was very upset that Donald did this and that she wanted to be reunited with him. She had tried to make contact with him by sending messages through other people, as John T. did not allow her access to a phone.

During intake it was noted that Tiffani had multiple bruises and burn marks on her legs and arms. She reported that Donald had slapped her when he felt she did not behave and that John T. burned her with cigarettes. Tiffani has been treated for several sexually transmitted infections (STIs) at local clinics and is currently on an antibiotic for a kidney infection. Although she was given condoms by Donald and John T. for her “dates,” there were several “Johns” who refused to use them. It appears that over the last 2 years, Tiffani has had neither outside support nor interactions with anyone beyond Donald, John T., and some other young women also being prostituted.

Other members of the Bradley family include Tiffani’s 33-year-old mother, Shondra; Tiffani’s 38-year-old father, Robert; and Tiffani’s 13-year-old sister, Diana. Shondra and Robert have been separated for a little over a year and have started dating other people. Diana currently resides with her mother and Anthony, her mother’s new boyfriend. Shondra and Anthony abuse a variety of drugs, including marijuana and methamphetamine.

Robert also abuses a number of drugs and has recently been arrested for possession of crack cocaine. Robert has been arrested several times over the last 5 years: twice for domestic violence calls and twice for drug possession. He is currently in jail awaiting sentencing.

The goals Tiffani and I set in our initial sessions centered on helping her feel safe and secure in her new home and utilizing as many of the available resources as possible. Through individual and group counseling, Tiffani will have the opportunity to discuss her experiences prior to coming to Teens First, including what led to her relationship with Donald. A long-term goal I presented was to help her understand that Donald, the person who she maintained “is the love of my life,” had actually had a negative impact on her life. Tiffani listed some of her own long-term goals, including obtaining a General Education Development (GED) credential, getting her own apartment, getting a job, and reunifying with her sister.

During our sessions over the year, Tiffani gave a rather in-depth description of her childhood. At first Tiffani provided a family history that was filled with only happy memories. She remembered her life up to age 8 as filled with moments of joy. She remembered going to school, playing with her sister, and her mother and father getting along.

As we continued to meet, Tiffani shared what she remembered as a gradual but definitive change in the family dynamics around the time when she turned 8 years old. She remembered being awakened by music and laughter in the early hours of the morning. When she went downstairs to investigate, she saw her parents along with her uncle Nate passing a pipe back and forth between them. She remembered asking them what they were doing and her mother saying, “adult things” and putting her back in bed.

Tiffani remembered being woken up by noise several times after that and seeing her father and her uncle passing the pipe between them. Sometimes her mother was there and sometimes she was not. Often when her mother was not there, Nate would see her and ask her to come over. Her father would sometimes ask her to show them the

dance that she had learned at school. When she danced, her father and Nate would laugh and offer her pocket change. Sometimes they were joined by their friend Jimmy.

For years the music and noise downstairs continued, later accompanied by screams and shouting and sounds of people fighting. One morning, Shondra yelled at Robert to “get up and go to work.” Tiffani and Diana saw Robert come out of the bedroom and slap Shondra so hard she was knocked down. Robert then went back into the bedroom.

Tiffani also noticed significant changes in her home’s appearance. The home, which was never fancy, was almost always neat and tidy. Tiffani noticed that dust would gather around the house, dishes would pile up in the sink, dirt would remain on the floor, and clothes would go for long periods of time without being washed. Tiffani remembered cleaning her own clothes and making meals for herself and her sister during this period. Sometimes Tiffani and her sister would come downstairs in the morning to find empty beer cans and liquor bottles on the kitchen table along with the pipe. Her parents would be in the bedroom, and Tiffani and her sister would leave the house and go to school by themselves. Tiffani was unclear if her parents were working or how the bills were paid. Often there was not enough food to feed everyone and she would go to bed hungry.

During one session, Tiffani described an incident of sexual abuse. One night she was awoken by her uncle Nate and his friend Jimmy in her room. Her parents were apparently out, and they were the only adults in the home. They asked her if she wanted to come downstairs and show them the new dances she learned at school. Once downstairs, Nate and Jimmy put some music on and started to dance. They asked Tiffani to start dancing with them, which she did. While they were dancing, Jimmy spilled some beer on her. Nate said she had to go to the bathroom to clean up. Nate, Jimmy, and Tiffani all went to the bathroom. Nate asked Tiffani to take her clothes off so she could get in the bath. Tiffani hesitated to do this, but Nate insisted it was okay since he and Jimmy were family. Tiffani eventually relented and began to wash up. Nate would tell her that she missed a spot and would scrub the area with his hands.

After this incident, others occurred, with increasing levels of molestation each time. Tiffani felt very bad about this, but had difficulty explaining why, even to herself. She was very afraid of everyone in her family except her sister Diana. She was also afraid that Diana might be subjected to the same thing.

The last time it happened, when Tiffani was 14, she pretended to be willing to dance for them, but when she got downstairs she ran out the front door of the house. Tiffani ran down the block to her school because, as she said, it was one of the few places where she felt safe. She said she was barefoot and in her pajamas and it was very cold. About halfway to her school, a car stopped, and a man inside asked her where she was going. When Tiffani replied that she was going to school, the man asked why she was going to school in the middle of the night. Tiffani did not want to tell him the whole story, so she told him that there was trouble at home and she just wanted to go to school early.

The man introduced himself as Donald and asked her why she did not go to her boyfriend’s house. When Tiffani said she did not have a boyfriend, Donald replied that if she had a boyfriend, she would have somebody to take care of her and keep her safe when these things happened. He then offered to be her boyfriend. Tiffani did not say anything, but when Donald then offered to give her a ride, she agreed and got in the car.

Donald took Tiffani to his apartment, explaining that the school would be closed for hours. When they got to his apartment, Donald fed Tiffani and gave her beer, explaining that it would help keep her warm. Tiffani did not like the taste of the beer, but at Donald’s insistence, she drank it.

When Tiffani was drunk, Donald began kissing her, and they had sex. Tiffani knew about sex from school and some of her girlfriends but she had never had it with anyone before. She was grateful to Donald because he had helped her get away from Nate and Jimmy. Donald had also told her that he loved her and they would be together forever. Tiffani was also afraid that if she did not have sex, Donald would not let her stay and she had nowhere else to go.

For the next 3 days, Donald brought her food and beer and had sex with her several more times. Donald told Tiffani that she was not allowed to do anything without his permission. This included watching TV, going to the bathroom, taking a shower, and eating and drinking.

Donald bought Tiffani a dress, explaining to her that she was going to “find a date” and get men to pay her to have sex with her. When Tiffani said she did not want to do that, Donald hit her several times. Donald explained

The Bradley Family

Robert Bradley: father, 38

Shondra Bradley: mother, 33

Nate Bradley: uncle, 36

Tiffani Bradley: daughter, 16

Diana Bradley: daughter, 13

Donald: Tiffani’s self-described husband and her former pimp

Shondra currently lives with her boyfriend, Anthony

that if she didn't do it, he would get her sister, Diana, and make her do it instead. Out of fear for her sister, Tiffani relented and did what Donald told her to do.

Tiffani and I met over the course of a year for individual sessions. We talked often about her continued desire to be reunited with Donald. We discussed what Donald represented for her and why he was such an important part of her life. She often described him as the person who “saved” her and felt she owed much to him. She vividly remembered the fear she felt the nights Nate and Jimmy touched her, and she was convinced they would have raped her that last night. My efforts were to help her recognize that Donald was not a savior, but someone who did, in fact, rape her and then force her into prostitution. A lot of time and discussion went into changing this cognition around Donald and their relationship.

After about six months at Teens First, Tiffani said that she had a strong desire to see her sister and her mother, and I helped to arrange a family session at the agency. Tiffani and I talked about what her hopes were for the meeting and her intent for scheduling this session. Tiffani first and foremost just wanted to see them and hug them. She had not seen either of them in over two years and missed them very much. Tiffani also felt some anger toward her mother that she wanted to be able to share in a safe environment. She said she felt that both her parents did not do enough to protect her and that they should have known better than to have let Nate and Jimmy into the house when they were not home. She also said she felt her mother should have tried harder to find her when she was with Donald. I wanted her to be realistic about the potential outcome of the meeting, so I did my best to explain that the session might not provide all of the answers she hoped for. We were aware, through a conversation with her sister, that her mother was still using drugs, and we talked about how this might cloud her mother's ability to engage in a substantial conversation.

In the family session, Shondra was very critical of Tiffani and her current situation. She ultimately blamed Tiffani for her current state. When Tiffani confronted her mother about the drug use and the lack of parental guidance and protection, Shondra denied ever having used drugs. She told Tiffani she was exaggerating and a liar and that neither she nor Tiffani's father ever put her in harm's way.

Throughout our time working together, Tiffani utilized all of the services at the agency and stopped trying to contact Donald. She had learned that he had actually gotten married to one of the other women that worked for him, and this made her very angry. She has passed her GED test and started working at a local fast food restaurant. She plans on applying to a community college and a fashion institute.

Key to Acronyms

GED: General Education
Development

STI: Sexually Transmitted
Infection

The Petrakis Family

Helen Petrakis is a 52-year-old heterosexual married female of Greek descent who says that she feels overwhelmed and “blue.” She came to our agency at the suggestion of a close friend who thought Helen would benefit from having a person who could listen. Although she is uncomfortable talking about her life with a stranger, Helen said that she decided to come for therapy because she worries about burdening friends with her troubles. Helen and I have met four times, twice per month, for individual therapy in 50-minute sessions.

Helen consistently appears well-groomed. She speaks clearly and in moderate tones and seems to have linear thought progression; her memory seems intact. She claims no history of drug or alcohol abuse, and she does not identify a history of trauma. Helen says that other than chronic back pain from an old injury, which she manages with acetaminophen as needed, she is in good health.

Helen has worked full time at a hospital in the billing department since graduating from high school. Her husband, John (60), works full time managing a grocery store and earns the larger portion of the family income. She and John live with their three adult children in a 4-bedroom house. Helen voices a great deal of pride in the children. Alec, 27, is currently unemployed, which Helen attributes to the poor economy. Dmitra, 23, whom Helen describes as smart, beautiful, and hardworking, works as a sales consultant for a local department store. Athina, 18, is an honors student at a local college and earns spending money as a hostess in a family friend’s restaurant; Helen describes her as adorable and reliable.

In our first session, I explained to Helen that I was an advanced year intern completing my second field placement at the agency. I told her I worked closely with my field supervisor to provide the best care possible. She said that was fine, congratulated me on advancing my career, and then began talking. I listened for the reasons Helen came to speak with me.

I asked Helen about her community, which, she explained, centered on the activities of the Greek Orthodox Church. She and John were married in that church and attend services weekly. She expects that her children will also eventually wed there. Her children, she explained, are religious but do not regularly go to church because they are very busy. She believes that the children are too busy to be expected to help around the house. Helen shops, cooks, and cleans for the family, and John sees to yard care and maintains the family’s cars. When I asked whether the children contributed to the finances of the home, Helen looked shocked and said that John would find it deeply insulting to take money from his children. As Helen described her life, I surmised that the Petrakis family holds strong family bonds within a large and supportive community.

Helen is responsible for the care of John’s 81-year-old widowed mother, Magda, who lives in an apartment 30 minutes away. Until recently, Magda was self-sufficient, coming for weekly family dinners and driving herself shopping and to church. But 6 months ago, she fell and broke her hip and was also recently diagnosed with early signs of dementia. Through their church, Helen and John hired a reliable and trusted woman to check in on Magda a couple of days each week. Helen goes to see Magda on the other days, sometimes twice in one day, depending on Magda’s needs. She buys her food, cleans her home, pays her bills, and keeps track of her medications. Helen says she would like to have the helper come in more often, but she cannot afford it. The money to pay for help is coming out of the couple’s vacations savings. Caring for Magda makes Helen feel as if she is failing as a wife and mother because she no longer has time to spend with her husband and children.

Helen sounded angry as she described the amount of time she gave toward Magda’s care. She has stopped going shopping and out to eat with friends because she can no longer find the time. Lately, John has expressed displeasure with meals at home, as Helen has been cooking less often and brings home takeout. She sounded defeated when she described an incident in which her son, Alec, expressed disappointment in her because she could not provide him with clean laundry. When she cried in response, he offered to help care for his grandmother. Alec proposed moving in with Magda.

Helen wondered if asking Alec to stay with his grandmother might be good for all of them. John and Alec had been arguing lately, and Alec and his grandmother had always been very fond of each other. Helen thought she could offer Alec the money she gave Magda’s helper.

I responded that I thought Helen and Alec were using creative problem solving and utilizing their resources well in crafting a plan. I said that Helen seemed to find good solutions within her family and culture. Helen appeared concerned as I said this, and I surmised that she was reluctant to impose on her son because she and her husband

seemed to value providing for their children's needs rather than expecting them to contribute resources. Helen ended the session agreeing to consider the solution we discussed to ease the stress of caring for Magda.

In our second session, Helen said that her son again mentioned that he saw how overwhelmed she was and wanted to help care for Magda. While Helen was not sure this was the best idea, she saw how it might be helpful for a short time. Nonetheless, her instincts were still telling her that this could be a bad plan. Helen worried about changing the arrangements as they were and seemed reluctant to step away from her integral role in Magda's care, despite the pain it was causing her. In this session, I helped Helen begin to explore her feelings and assumptions about her role as a caretaker in the family. Helen did not seem able to identify her expectations of herself as a caretaker. She did, however, resolve her ambivalence about Alec's offer to care for Magda. By the end of the session, Helen agreed to have Alec live with his grandmother.

In our third session, Helen briskly walked into the room and announced that Alec had moved in with Magda and it was a disaster. Since the move, Helen had had to be at the apartment at least once daily to intervene with emergencies. Magda called Helen at work the day after Alec moved in to ask Helen to pick up a refill of her medications at the pharmacy. Helen asked to speak to Alec, and Magda said he had gone out with two friends the night before and had not come home yet. Helen left work immediately and drove to Magda's home. Helen angrily told me that she assumed that Magda misplaced the medications, but then she began to cry and said that the medications were not misplaced, they were really gone. When she searched the apartment, Helen noticed that the cash box was empty and that Magda's checkbook was missing two checks. Helen determined that Magda was robbed, but because she did not want to frighten her, she decided not to report the crime. Instead, Helen phoned the pharmacy and explained that her mother-in-law, suffering from dementia, had accidentally destroyed her medication and would need refills. She called Magda's bank and learned that the checks had been cashed. Helen cooked lunch for her mother-in-law and ate it with her. When a tired and disheveled Alec arrived back in the apartment, Helen quietly told her son about the robbery and reinforced the importance of remaining in the building with Magda at night.

Helen said that the events in Magda's apartment were repeated 2 days later. By this time in the session Helen was furious. With her face red with rage and her hands shaking, she told me that all this was my fault for suggesting that Alec's presence in the apartment would benefit the family. Jewelry from Greece, which had been in the family for generations, was now gone. Alec would never be in this trouble if I had not told Helen he should be permitted to live with his grandmother. Helen said she should know better than to talk to a stranger about private matters.

Helen cried, and as I sat and listened to her sobs, I was not sure whether to let her cry, give her a tissue, or interrupt her. As the session was nearing the end, Helen quickly told me that Alec has struggled with maintaining sobriety since he was a teen. He is currently on 2 years' probation for possession and had recently completed a rehabilitation program. Helen said she now realized Alec was stealing from his grandmother to support his drug habit. She could not possibly tell her husband because he would hurt and humiliate Alec, and she would not consider telling the police. Helen's solution was to remove the valuables and medications from the apartment and to visit twice a day to bring supplies and medicine and check on Alec and Magda.

After this session, it was unclear how to proceed with Helen. I asked my field instructor for help. I explained that I had offered support for a possible solution to Helen's difficulties and stress. In rereading the progress notes in Helen's chart, I realized I had misinterpreted Helen's reluctance to ask Alec to move in with his grandmother. I felt terrible about pushing Helen into acting outside of her own instincts.

My field instructor reminded me that I had not forced Helen to act as she had and that no one was responsible for the actions of another person. She told me that beginning social workers do make mistakes and that my errors were part of a learning process and were not irreparable. I was reminded that advising Helen, or any client, is ill-advised. My field instructor expressed concern about my ethical and legal obligations to protect Magda. She suggested that I call the county office on aging and adult services to research my duty to report, and to speak to the agency director about my ethical and legal obligations in this case.

In our fourth session, Helen apologized for missing a previous appointment with me. She said she awoke the morning of the appointment with tightness in her chest and a feeling that her heart was racing. John drove Helen to the emergency room at the hospital in which she works. By the time Helen got to the hospital, she could not

The Petrakis Family

Magda Petrakis: mother
of John Petrakis, 81

John Petrakis: father, 60

Helen Petrakis: mother, 52

Alec Petrakis: son, 27

Dmitra Petrakis: daughter, 23

Athina Petrakis: daughter, 18

catch her breath and thought she might pass out. The hospital ran tests but found no conclusive organic reason to explain Helen's symptoms.

I asked Helen how she felt now. She said that since her visit to the hospital, she continues to experience shortness of breath, usually in the morning when she is getting ready to begin her day. She said she has trouble staying asleep, waking two to four times each night, and she feels tired during the day. Working is hard because she is more forgetful than she has ever been. Her back is giving her trouble, too. Helen said that she feels like her body is one big tired knot.

I suggested that her symptoms could indicate anxiety and she might want to consider seeing a psychiatrist for an evaluation. I told Helen it would make sense, given the pressures in her life, that she felt anxiety. I said that she and I could develop a treatment plan to help her address the anxiety. Helen's therapy goals include removing Alec from Magda's apartment and speaking to John about a safe and supported living arrangement for Magda.

The Cortez Family

Paula is a 43-year-old HIV-positive Latina woman originally from Colombia. She is bilingual, fluent in both Spanish and English. Paula lives alone in an apartment in Queens, NY. She is divorced and has one son, Miguel, who is 20 years old. Paula maintains a relationship with her son and her ex-husband, David (46). Paula raised Miguel until he was 8 years old, at which time she was forced to relinquish custody due to her medical condition. Paula is severely socially isolated as she has limited contact with her family in Colombia and lacks a peer network of any kind in her neighborhood. Paula identifies as Catholic, but she does not consider religion to be a big part of her life.

Paula came from a moderately well-to-do family. She reports suffering physical and emotional abuse at the hands of both her parents, who are alive and reside in Colombia with Paula's two siblings. Paula completed high school in Colombia, but ran away when she was 17 years old because she could no longer tolerate the abuse at home. Paula became an intravenous drug user (IVDU), particularly of cocaine and heroin. David, who was originally from New York City, was one of Paula's "drug buddies." The two eloped, and Paula followed David to the United States. Paula continued to use drugs in the United States for several years; however, she stopped when she got pregnant with Miguel. David continued to use drugs, which led to the failure of their marriage.

Once she stopped using drugs, Paula attended the Fashion Institute of Technology (FIT) in New York City. Upon completing her BA, Paula worked for a clothing designer, but realized her true passion was painting. She has a collection of more than 100 drawings and paintings, many of which track the course of her personal and emotional journey. Paula held a full-time job for a number of years before her health prevented her from working. She is now unemployed and receives Supplemental Security Insurance (SSI) and Medicaid.

Paula was diagnosed with bipolar disorder. She experiences rapid cycles of mania and depression when not properly medicated, and she also has a tendency toward paranoia. Paula has a history of not complying with her psychiatric medication treatment because she does not like the way it makes her feel. She often discontinues it without telling her psychiatrist. Paula has had multiple psychiatric hospitalizations but has remained out of the hospital for at least five years. Paula accepts her bipolar diagnosis, but demonstrates limited insight into the relationship between her symptoms and her medication.

Paula was diagnosed HIV positive in 1987. Paula acquired AIDS several years later when she was diagnosed with a severe brain infection and a T-cell count less than 200. Paula's brain infection left her completely paralyzed on the right side. She lost function of her right arm and hand, as well as the ability to walk. After a long stay in an acute care hospital in New York City, Paula was transferred to a skilled nursing facility (SNF) where she thought she would die. It is at this time that Paula gave up custody of her son. However, Paula's condition improved gradually. After being in the SNF for more than a year, Paula regained the ability to walk, although she does so with a severe limp. She also regained some function in her right arm. Her right hand (her dominant hand) remains semiparalyzed and limp. Over the course of several years, Paula taught herself to paint with her left hand and was able to return to her beloved art. In 1996, when highly active antiretroviral therapy (HAART) became available, Paula began treatment. She responded well to HAART and her HIV/AIDS was well controlled.

In addition to her HIV/AIDS disease, Paula is diagnosed with hepatitis C (Hep C). While this condition was controlled, it has reached a point where Paula's doctor is recommending she begin treatment. Paula also has significant circulatory problems, which cause her severe pain in her lower extremities. She uses prescribed narcotic pain medication to control her symptoms. Paula's circulatory problems have also led to chronic ulcers on her feet that will not heal. Treatment for her foot ulcers demands frequent visits to a wound care clinic. Paula's pain paired with the foot ulcers make it difficult for her to ambulate and leave her home. As with her psychiatric medication, Paula has a tendency not to comply with her medical treatment. She often disregards instructions from her doctors and resorts to holistic treatments like treating her ulcers with chamomile tea. Working with Paula can be very frustrating because she is often doing very well medically and psychiatrically. Then, out of the blue, she stops her treatment and deteriorates quickly.

I met Paula as a social worker employed at an outpatient comprehensive care clinic located in an acute care hospital in New York City. The clinic functions as an interdisciplinary operation and follows a continuity of care model. As a result, clinic patients are followed by their physician and social worker on an outpatient basis and on an inpatient basis when admitted to the hospital. Thus, social workers interact not only with doctors from the clinic, but also with doctors from all services throughout the hospital.

After working with Paula for almost six months, she called to inform me that she was pregnant. Her news was shocking because she did not have a boyfriend and never spoke of dating. Paula explained that she met a man at a flower shop, they spoke several times, he visited her at her apartment, and they had sex. Paula thought he was a “stand up guy,” but recently everything had changed. Paula began to suspect that he was using drugs because he had started to become controlling and demanding. He showed up at her apartment at all times of the night demanding to be let in. He called her relentlessly, and when she did not pick up the phone, he left her mean and threatening messages. Paula was fearful for her safety.

Given Paula’s complex medical profile and her psychiatric diagnosis, her doctor, psychiatrist, and I were concerned about Paula maintaining the pregnancy. We not only feared for Paula’s and the baby’s health, but also for how Paula would manage caring for a baby. Paula also struggled with what she should do about her pregnancy. She seriously considered having an abortion. However, her Catholic roots paired with seeing an ultrasound of the baby reinforced her desire to go through with the pregnancy.

The primary focus of treatment quickly became dealing with Paula’s relationship with the baby’s father. During sessions with her psychiatrist and me, Paula reported feeling fearful for her safety. The father’s relentless phone calls and voicemails rattled Paula. She became scared, slept poorly, and her paranoia increased significantly. During a particular session, Paula reported that she had started smoking to cope with the stress she was feeling. She also stated that she had stopped her psychiatric medication and was not always taking her HAART. When we explored the dangers of Paula’s actions, both to herself and the baby, she indicated that she knew what she was doing was harmful but she did not care. After completing a suicide assessment, I was convinced that Paula was decompensating quickly and at risk of harming herself and/or her baby. I consulted with her psychiatrist, and Paula was involuntarily admitted to the psychiatric unit of the hospital. Paula was extremely angry at me for the admission. She blamed me for “locking her up” and not helping her. Paula remained on the unit for 2 weeks. During this stay she restarted her medications and was stabilized. I tried to visit Paula on the unit, but the first two times I showed up she refused to see me. Eventually, Paula did agree to see me. She was still angry, but she was able to see that I had acted with her best interest in mind, and we were able to repair our relationship. As Paula prepared for discharge, she spoke more about the father and the stress that had driven her to the admission in the first place. Paula agreed that despite her fears she had to do something about the situation. I helped Paula develop a safety plan, educated her about filing for a restraining order, and referred her to the AIDS Law Project, a not-for-profit organization that helps individuals with HIV handle legal issues. With my support and that of her lawyer, Paula filed a police report and successfully got the restraining order. Once the order was served, the phone calls and visits stopped, and Paula regained a sense of control over her life.

From a medical perspective, Paula’s pregnancy was considered “high risk” due to her complicated medical situation. Throughout her pregnancy, Paula remained on HAART, pain, and psychiatric medication, and treatment for her Hep C was postponed. During the pregnancy the ulcers on Paula’s feet worsened and she developed a severe bone infection, osteomyelitis, in two of her toes. Without treatment the infection was extremely dangerous to both Paula and her baby. Paula was admitted to a medical unit in the hospital where she started a 2-week course of intravenous (IV) antibiotics. Unfortunately, the antibiotics did not work, and Paula had to have portions of two of her toes amputated with limited anesthesia due to the pregnancy, extending her hospital stay to nearly a month.

The condition of Paula’s feet heightened my concern and the treatment team’s concerns about Paula’s ability to care for her baby. There were multiple factors to consider. In the immediate term, Paula was barely able to walk and was therefore unable to do anything to prepare for the baby’s arrival (e.g., gather supplies, take parenting class, etc.). In the medium term, we needed to address how Paula was going to care for the baby day-to-day, and we needed to think about how she would care for the baby at home given her physical limitations (i.e., limited ability to ambulate and limited use of her right hand) and her current medical status. In addition, we had to consider what she would do with the baby if she required another hospitalization. In the long term, we needed to think about permanency planning for the baby or for what would happen to the baby if Paula died. While Paula recognized the importance of all of these issues, her anxiety level was much lower than mine and that of her treatment team. Perhaps she did not see the whole picture as we did, or perhaps she was in denial. She repeatedly told me, “I know, I know. I’m just going to do it. I raised my son and I am going to take care of this baby too.” We really did not have an answer for her limited emotional response, we just needed to meet her where she was and move on. One of the things that amazed me most about Paula was that she had a great ability to rally people around her. Nurses, doctors, social workers: we all wanted to help her even when she tried to push us away.

The Cortez Family

David Cortez: father, 46

Paula Cortez: mother, 43

Miguel Cortez: son, 20

While Paula was in the hospital unit, we were able to talk about the baby's care and permanency planning. Through these discussions, Paula's social isolation became more and more evident. Paula had not told her parents in Colombia that she was having a baby. She feared their disapproval and she stated, "I can't stand to hear my mother's negativity." Miguel and David were aware of the pregnancy, but they each had their own lives. David was remarried with children, and Miguel was working and in school full-time. The idea of burdening him with her needs was something Paula would not consider. There was no one else in Paula's life. Therefore, we were forced to look at options outside of Paula's limited social network.

After a month in the hospital, Paula went home with a surgical boot, instructions to limit bearing weight on her foot, and a list of referrals from me. Paula and I agreed to check in every other day by telephone. My intention was to monitor how she was feeling, as well as her progress with the referrals I had given her. I also wanted to provide her with support and encouragement that she was not getting from anywhere else. On many occasions, I hung up the phone frustrated with Paula because of her procrastination and lack of follow-through. But ultimately she completed what she needed to for the baby's arrival. Paula successfully applied for WIC, the federal Supplemental Nutrition Program for Women, Infants, and Children, and was also able to secure a crib and other baby essentials.

Paula delivered a healthy baby girl. The baby was born HIV negative and received the appropriate HAART treatment after birth. The baby spent a week in the neonatal intensive care unit, as she had to detox from the effects of the pain medication Paula took throughout her pregnancy. Given Paula's low income, health, and Medicaid status, Paula was able to apply for and receive 24/7 in-home child care assistance through New York's public assistance program. Depending on Paula's health and her need for help, this arrangement can be modified as deemed appropriate. Miguel did take a part in caring for his half sister, but his assistance was limited. Ultimately, Paula completed the appropriate permanency planning paperwork with the assistance of the organization The Family Center. She named Miguel the baby's guardian should something happen to her.

Key to Acronyms

AIDS:	Acquired Immunodeficiency Syndrome
HAART:	Highly Active Antiretroviral Therapy
HIV:	Human Immunodeficiency Virus
IVDU:	Intravenous Drug User
SNF:	Skilled Nursing Facility
SSI:	Supplemental Security Insurance
WIC:	Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX

Reflection Questions

The social worker in each of the cases answered these additional questions as follows.

The Hernandez Family

1. What specific intervention strategies (skills, knowledge, etc.) did you use to address this client situation?

I used role-playing to help the family members view how each of them perceived their behaviors. For example, Juan Jr. acted like Juan Sr. when he came home from work each day. Juan Jr. portrayed his father as grumpy and irritated at the sight of the boys. His tone was angry and he yelled instead of using a calm tone. Juan Sr. was shocked at how Juan Jr. depicted him and his interactions with his family members. Drawing on family systems theory and the strengths perspective, I highlighted the family's assets and made sure to recognize that they were the experts of their own life and experiences. I also wanted to treat the family as a unit rather than concentrate on one "identified client." Therefore, rather than focusing on Juan Jr. and why he called, I had the family express their thoughts and feelings about interactions in the home on a daily basis. We did review how each felt about the call to the ACS worker, but the intent was to release any underlying resentment or anger felt by any of the family members. Using a genogram helped to identify patterns in the family history. This clearly unlocked some firmly held beliefs around expectations of how children should behave and shared financial burdens that no longer worked for this family.

2. Which theory or theories did you use to guide your practice?

I used the strengths perspective and family systems theory. I focused on what the family had and how they could access the available resources that had yet been untapped. I looked at how the family interacted as a unit rather than four separate individuals. We worked together to identify how each member of the family affected the others in various ways—sometimes in a positive manner and sometimes in ways that were challenging and provoking.

3. What were the identified strengths of the client(s)?

It was clear from the beginning that Elena and Juan Sr. loved each other and their sons. There was clearly a bond among the family members that appeared to get stronger over the course of the sessions. Elena and Juan Sr. were able to see that while they had not elected to seek counseling, family and parenting sessions could be helpful to them and their children. They allowed me to learn about their family and took great pride in describing their heritage and culture.

4. What were the identified challenges faced by the client(s)?

The biggest challenge to this family was the financial concern they faced each day. It was clear that their economic situation weighed heavily on all members of the family. The need for Juan Sr. to put in many hours of overtime negatively affected his behavior toward his children. The children were perhaps acting out due to the fear and anxiety they felt about money issues, which were constantly being discussed in the home. Through our discussion about money management, it was clear that neither Elena nor Juan Sr. had sat down and completed a budget. Many expenses were unaccounted for in their bank register and neither balanced the checkbook regularly.

5. What were the agreed-upon goals to be met to address the concern?

Because the clients were mandated to services, the goals were essentially set by the ACS worker. That being said, I tried to work with the family to identify potential topics that they wanted to discuss during our family sessions. Elena and Juan Sr. said they wanted to learn more about managing their money.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client system? If so, what type of research did you do to prepare?

Because I felt that the ACS worker had neglected to take into consideration the Hernandez's culture when she made the referral, I was very aware that I needed to learn about them and their beliefs around parenting. As a Caucasian woman, I was not familiar with the form of discipline they had used nor did I understand their perspective as Latino (Puerto Rican) individuals. I asked them many questions about their culture and how children are treated and viewed. They shared many stories of their own childhood with me and helped me to understand their perspective based on their cultural lens.

7. What local, state, or federal policies could (or did) affect this case?

It would positively affect cases like this if ACS, a state agency, decided that each potential abuse case needed to be reviewed for cultural competence in order to eliminate or reduce bias.

8. How would you advocate for social change to positively affect this case?

I would encourage such a policy as described above to be implemented across all child protective service agencies. Further, I would encourage that a strengths perspective be adopted by child protective workers when addressing these cases.

9. Were there any legal or ethical issues present in the case? If so, what were they and how were they addressed?

The legal issues surrounded the fact that I was mandated to contact the ACS worker about the clients' progress or lack thereof. Ethically, I felt torn about calling the ACS worker but knew that in the end it was what I had to do.

10. How can evidence-based practice be integrated into this situation?

It was integrated through the use of an evidenced-based program to teach parenting skills.

11. Is there any additional information that is important to the case?

No, there is no additional information.

12. Describe any additional personal reflections about this case.

I believe that including a positive report when I notified the ACS that the clients had missed too many classes was helpful in advocating for them. As their social worker, I believed that they had tried to attend the classes. I felt it was my responsibility to advocate for them and share all of the positive strides they made while working with me. I highlighted their strengths when talking with the ACS worker rather than focusing on the negatives. The clients recognized this and did not get angry with me when I told them I had to contact the ACS worker. They continued to contact me to share their sons' milestones and elected to participate in some holiday events at the agency and eventually the financial literacy program we offered. I wish I had reported the inappropriate comments made by the ACS worker to her supervisor. I feel now that I should have said something and regret not reporting these statements.

The Parker Family

1. What specific intervention strategies (skills, knowledge, etc.) did you use to address this client situation?

I encouraged Sara and Stephanie to work together in clearing out the apartment with the common goal of being able to remain in their apartment. Sara and Stephanie thus both had some control in the cleaning and the choice of items to be discarded. I developed a rapport with Jane and was able to enlist her help in cleaning. I explored alternative housing options for both Sara and Stephanie. I also improved Sara's outpatient psychiatric care by arranging treatment with a geriatric psychiatrist.

2. Which theory or theories did you use to guide your practice?

Family therapy and engagement was essential in encouraging Sara and Stephanie to work together in cleaning the apartment and in obtaining the assistance of Jane in the process.

3. What were the identified strengths of the client(s)?

Stephanie was organized and kept her living area clean. She was working part-time and was training to become a cashier. Sara was attending a senior day program regularly. Sara and Stephanie were willing to work together and were open to suggestions and making changes.

4. What were the identified challenges faced by the client(s)?

Sara and Stephanie were at risk of removal from their apartment. Sara had poor insight into her hoarding, which made cleaning up the apartment very challenging. Sara was estranged from Jane, which was the only close family member who could be of assistance in participating in an intervention to clean the apartment.

5. What were the agreed-upon goals to be met to address the concern?

Sara and Stephanie made the decision to work together to clean up the apartment with the goal of being able to remain living in their apartment. Sara gave me permission to contact Jane with the intention of enlisting her help in cleaning up the apartment. Sara also agreed to neuropsychological testing and changed her outpatient psychiatric treatment. Both Stephanie and Sara agreed to each keep one favorite cat, and Stephanie would look for homes for the remaining cats.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client system? If so, what type of research did you do to prepare?

There were no cultural issues that needed to be addressed.

7. What local, state, or federal policies could (or did) affect this case?

Adult Protective Services was monitoring this family and had the authority to remove them from their apartment if the situation was deemed dangerous or if the family was unable to clean the apartment and improve living conditions. Intensive Case Management services were put in place by Adult Protective Services to assess the needs of the family and to develop a plan and resources to meet these needs. An Intensive Case Manager met with the family weekly to address a variety of issues and actively begin implementing planned interventions.

8. How would you advocate for social change to positively affect this case?

There is tremendous pressure placed on hospitals by insurance companies to discharge patients within a short prescribed time. This poses a serious challenge for social workers, who often are responsible for discharge planning. There are ethical questions such as whether a patient is truly prepared for discharge and whether their discharge plan is optimum or hastily planned.

9. Were there any legal or ethical issues present in the case? If so, what were they and how were they addressed?

Adult Protective Services was monitoring this family and had the authority to remove them from their apartment if the situation was deemed dangerous. Intensive Case Management services were put into place by Adult Protective Services to assess the needs of the family. As the Intensive Case Manager, I met with the family weekly to address a variety of issues and develop a plan and appropriate interventions.

10. How can evidence-based practice be integrated into this situation?

Utilizing family therapy and engaging an estranged family member was essential to working with this family. Utilizing cognitive and behavioral therapy helped Sara finally acknowledge the condition of the apartment and prepared her to begin throwing out or giving away items to create a clean, habitable apartment.

11. Is there any additional information that is important to the case?

As their social worker, I reached out to an estranged family member and was eventually able to enlist her support. I was able to improve the quality of Sara's psychiatric treatment by arranging neuropsychological testing and treatment with a geriatric psychiatrist. I explored housing and community, local, and state resources.

12. Describe any additional personal reflections about this case.

I have concerns regarding Sara living alone, even with home care services in place. Sara will also need a follow-up appointment with the neurologist to determine if she is experiencing symptoms of early dementia.

The Logan Family**1. What specific intervention strategies (skills, knowledge, etc.) did you use to address this client situation?**

I used individual and family counseling, education, assessment, problem solving, and skills training in this situation.

2. Which theory or theories did you use to guide your practice?

I used systems, social learning, and conflict theories, as well as theories of moral reasoning, theories of cognition, and stage theories.

3. What were the identified strengths of the client(s)?

Eboni is a good student who is goal oriented and athletic. She has the support of family and friends, good health, and is not chemically dependent. Additionally, she is employed and has housing.

4. What were the identified challenges faced by the client(s)?

Eboni was dealing with teenage pregnancy and family discord.

5. What were the agreed-upon goals to be met to address the concern?

Eboni and I agreed that she would inform her family and process all of her options.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client system? If so, what type of research did you do to prepare?

No, there were no issues of cultural competence.

7. What local, state, or federal policies could (or did) affect this case?

Roe v. Wade, state adoption laws, and medical policies all affected this case.

8. How would you advocate for social change to positively affect this case?

Because there is a divide in society about abortion, it is difficult to look at social change from this perspective. However, there could be increased programming for single teenage mothers who would like to go to college and parent their child.

9. Were there any legal or ethical issues present in the case? If so, what were they and how were they addressed?

Termination of pregnancy, parental rights if the child is a minor, role the biological father plays in the decision-making process, and open versus closed adoption were all present in this case.

10. How can evidence-based practice be integrated into this situation?

There are evidence-based teenage pregnancy prevention programs that could be implemented in the school system.

11. Is there any additional information that is important to the case?

The final decision was left unanswered to provide the opportunity for discussion.

12. Describe any additional personal reflections about this case.

I have none.

The Johnson Family**1. What specific intervention strategies (skills, knowledge, etc.) did you use to address this client situation?**

I used anxiety-reducing strategies such as breathing exercises to help Talia regulate her physical responses to the memories of the sexual assault. I used education tools to help validate and normalize her reactions, sharing information on sexual assault trauma and PTSD. I used journaling, worksheets, and art to help her express her feelings in a safe manner when she felt she could not verbalize them. I worked to build a collaborative working relationship with her, spending a lot of time on building a rapport.

2. Which theory or theories did you use to guide your practice?

I used empowerment theory to guide my practice. I let Talia guide the sessions, and together we decided on goals and objectives. I never pressed her to share her story and I worked to make the time together feel safe and supportive. I always let her know she was in charge of the session and the content. Cognitive theory was used to help her challenge her thoughts of self-blame. Survivors often blame themselves for what has happened and question what they did in the scenario to encourage the sexual assault.

3. What were the identified strengths of the client(s)?

Talia was an intelligent, strong woman who worked hard at addressing what happened to her. She was physically active, had many strong friendships, and utilized her resources to the fullest extent. She had a loving mother and father who supported her through the process.

4. What were the identified challenges faced by the client(s)?

She was experiencing strong feelings of anxiety and was predisposed to anxiety on her mother's side of the family. She met with much skepticism about the sexual assault and was treated at times unfairly by friends and the hospital staff.

5. What were the agreed-upon goals to be met to address the concern?

Talia wanted to feel better overall, but in particular she wanted to address her anxiety attacks. Together we created mini goals to help her manage her anxiety and find ways to express her feelings about what happened. Weekly, we would set up goals around her use of the journal, her breathing exercises, and running.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client system? If so, what type of research did you do to prepare?

For this case, I needed to be aware of her age and development. I was also aware of the high rates of sexual assault on college campuses. I took into consideration her connection to her family of origin and her sorority sisters.

7. What local, state, or federal policies could (or did) affect this case?

The university's policy for addressing sexual assault cases could and did affect the situation. A dean is assigned the case and makes his or her determination after hearing from both sides. Had the dean not found Eric guilty, Talia would have had to be on campus for a year with a man who sexually assaulted her. Further, it was required that Talia be face-to-face with Eric in the dean's office. She then had to state the charges against him. This could potentially re-victimize and traumatize her. Lastly, Talia's assault had to be reported to the university's campus safety administrator in accordance with the Clery Act (a federal regulation).

4. What were the identified challenges faced by the client(s)?

The client had symptoms of PTSD, he was self-medicating, and he was depressed and isolating himself from his family.

5. What were the agreed-upon goals to be met to address the concern?

Jake and I agreed the goals for him were to follow-up with the psychiatrist to monitor his medication, attend weekly individual therapy sessions with me to address his PTSD issues, start attending an Iraq veterans support group at the Vet Center to develop a network of veterans he could connect with, participate in couples counseling to improve his relationship with his wife, and consider attending a local AA meeting to aid in his sobriety.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client? If so, what research did you do to prepare?

I was aware of the culture connected to being in the military. Often those in the military do not speak up and share their feelings for fear of looking weak and ineffective. I recognized that stepping forward was difficult for Jake and reminded him of the use of confidentiality in our sessions.

7. What local, state, or federal policies could (or did) affect this case?

Policies that could be addressed are those that outline services for the military.

8. How would you advocate for social change to positively affect this case?

I would advocate for a policy change that would establish a program for all military personnel returning from combat. Both the veterans and their family members should be educated about the symptoms of PTSD, how it can be treated, and the services available for those returning from combat. Families should be prepared for what to expect when their loved one returns home.

9. Were there any legal or ethical issues present in this case? If so, what were they and how were they addressed?

There were no legal issues in this case.

10. How can evidence-based practice be integrated into this situation?

Evidence-based practice can be integrated into this situation by looking at previous research studies that relate to this client situation. Previous studies quantify and support PET for PTSD.

11. Is there any additional information that is important to the case?

There is no other information at this time.

12. Describe any additional personal reflections about this case.

As I reflected on this case, I was reminded that this war was one of the longest our country has engaged in. Unlike the Vietnam War, military personnel were often sent back to Iraq more than once, meaning they spent more time in the line of fire. Jake's case is typical of what happens when a person returns from a hostile environment. He had been running on adrenaline nonstop for months. The length of time in that environment and the things witnessed while there are factors that affect an individual's ability to function in an environment that is not hostile. Jake has had a hard time adjusting to being home because home was no longer the norm for him.

The Bradley Family**1. What specific intervention strategies (skills, knowledge, etc.) did you use to address this client situation?**

Various counseling skills including reflection, summarization, empathy, and rapport were used when Tiffani was sharing her life story. Cognitive behavioral therapy techniques helped Tiffani adjust her thoughts around her self-worth. Further, we addressed her feelings related to Donald and her potentially dangerous view of him as her savior.

2. Which theory or theories did you use to guide your practice?

We focused on Tiffani's goals and cognitive behavioral theory to help with her history of sexual abuse.

3. What were the identified strengths of the client(s)?

Tiffani's strengths lie in her dedication to her sister and her desire to be reunited with her. Another strength is that she no longer seems to be emotionally attached to her former pimp, Donald, and does not seem to be attached emotionally to her last pimp, John T.

4. What were the identified challenges faced by the client(s)?

Tiffani has had to become self-sufficient enough to care for herself.

5. What were the agreed-upon goals to be met to address the concern?

The goals were to help her utilize all of the services provided and address her traumatic experiences in her early childhood and with Donald and John T. Her goals included attaining a level of self-sufficiency by obtaining her GED, getting a job, and renting an apartment. She also wanted to reunite with her sister and begin a meaningful relationship with her.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client system? If so, what type of research did you do to prepare?

I had to understand her background and how she became involved with Donald and then John T. I learned about domestic human trafficking and the tactics used by pimps to maintain power and control over others.

7. What local, state, or federal policies could (or did) affect this case?

New laws and policies concerning human trafficking and their tie-in with laws that address youth who are prostituted affected this case.

8. How would you advocate for social change to positively affect this case?

I would advocate for a national policy that addresses young men and women as survivors of human trafficking rather than prostitutes in our legal system.

9. Were there any legal or ethical issues present in the case? If so, what were they and how were they addressed?

The legal issue in this case concerned the new policy on how youth are penalized by the court system when found guilty of prostitution. There was an ethical issue that was not identified in the narrative. The director of Teens First requested that I ask Tiffani if we could use her image and story to promote the agency's services. I felt it was unethical to present this request to her because it was still early in her healing process and there were potential unintended negative consequences that could occur that she might not consider due to her age.

10. How can evidence-based practice be integrated into this situation?

Evidence-based practice techniques are key methods used in the work with this client.

11. Is there any additional information that is important to the case?

While Tiffani was a client, the director of Teens First asked that I see if she would be willing to allow us to use her image and story to promote our services. I explained to the director that I felt Tiffani was in no position to make this decision. I explained that she had not been in treatment long enough to be able to truly separate herself from what had happened. I worried that seeing her image on posters throughout the city might negatively affect her over time. I also felt that due to her age, she could not clearly make this decision and comprehend the potential negative consequences that might occur by agreeing to this. For example, I worried that people on the street might recognize her from the advertisements and point her out and say demeaning things to her. I also wondered what effect this might have on her relationships with her family if they saw the advertisements. Finally, I was concerned that there might be retribution on the part of Donald or John T. if they saw the posters.

12. Describe any additional personal reflections about this case.

I had strong feelings over the ethics of using a client's image and story to market the agency. While in the end it is the client's decision, I did not feel she was in a position to make this decision clearly. Due to her age and the limited time in treatment, I felt she could easily be manipulated to do something she might regret later. I had mixed feelings about making this decision for her or presenting the situation for her to make on her own.

The Petrakis Family**1. What specific intervention strategies (skills, knowledge, etc.) did you use to address this client situation?**

I used solution-focused and then psychodynamic interventions.

2. Which theory or theories did you use to guide your practice?

I used family systems and environmental theories to guide my practice.

3. What were the identified strengths of the client(s)?

The identified strengths of the client were strong family bonds and good community support.

4. What were the identified challenges faced by the client(s)?

Helen found it challenging to manage good self-care while acting as the primary caretaker of a family member. She also was challenged by the substance abuse and risky behaviors of her adult son.

5. What were the agreed-upon goals to be met to address the concern?

There were three identified goals in Helen's therapy sessions. One was to develop behavioral interventions to help Helen manage her feelings of anxiety. The second was to help Helen arrange to have a psychiatric evaluation to determine if medication management would help her manage her anxiety. The third was to help Helen develop and secure a safe and supported housing plan for Magda.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client system? If so, what type of research did you do to prepare?

It was important to recognize that Helen lives within a specific ethnic community.

7. What local, state, or federal policies could (or did) affect this case?

Adult protection services are of primary concern to this case.

8. How would you advocate for social change to positively affect this case?

I would advocate for supportive services for primary caretakers, including respite arrangements, shopping services, and assistance with medication management for Magda.

9. Were there any legal or ethical issues present in the case? If so, what were they and how were they addressed?

The legal issues of Alec's substance abuse and theft were not addressed in this case. The legal and ethical issues of theft were also not addressed.

10. How can evidence-based practice be integrated into this situation?

Evidence-based treatment may be integrated into the treatment of both anxiety and supportive interventions for codependency among substance-abusing family members. I would help Helen to identify measurable and quantifiable behavioral goals for treatment, specify my interventions, and evaluate every 12 sessions to see if my interventions were successfully addressing Helen's goals.

11. Is there any additional information that is important to the case?

I think providing Helen with information about harm reduction approaches to understanding substance abuse would be helpful, should Helen be interested. I would also provide information about Al-Anon. I would be curious about whether Helen's church or community offered support for substance abusers, caregivers, or families of substance abusers. I would also inquire about case management services for the elderly and provide that information to Helen, if she expressed an interest.

12. Describe any additional personal reflections about this case.

Helen is very involved in the care of her family and is losing her energy to care for herself. I would work to help Helen recognize her own strength and resilience and begin to identify ways she can nurture and recharge herself.

The Cortez Family**1. What specific intervention strategies (skills, knowledge, etc.) did you use to address this client situation?**

Skills I used included engagement and repairing relationship, assessment, asking open-ended questions, gathering information, identifying presenting problems and treatment planning, coordination of and collaboration with an interdisciplinary team, and coordination of and collaboration with community resources. Interventions I used included providing support, prioritizing problems, setting small achievable goals, suicide assessment, and case management. I had knowledge of the hospital system, Medicaid and public assistance, and HIV/AIDS.

2. Which theory or theories did you use to guide your practice?

My practice was guided by strengths perspective, motivational interviewing, psychodynamic theory, and goal-oriented practice.

3. What were the identified strengths of the client(s)?

Paula had many strengths. She was intelligent, completing both high school and college. She was able to create relationships with helping professionals. She was able to rally people around her. Paula was also a survivor and drew on her life experience. She taught herself how to use her nondominant hand to paint. Even though it took a lot of effort and convincing, Paula was able to get things done.

4. What were the identified challenges faced by the client(s)?

Paula's challenges included social isolation, physical illness, mental illness, and limited financial resources.

5. What were the agreed-upon goals to be met to address the concern?

We agreed that we would address Paula's domestic violence relationship by creating a safety plan and obtaining a restraining order. I would assist Paula in making a decision about keeping or ending her pregnancy. We would monitor Paula's mental and physical health. I would help Paula prepare for her baby's arrival by helping her get baby supplies; arrange for appropriate services such as in-home child care assistance, WIC benefits, baby's Medicaid; emotionally prepare for how life will change with a baby; and arrange for permanency planning.

6. Did you have to address any issues around cultural competence? Did you have to learn about this population/group prior to beginning your work with this client system? If so, what type of research did you do to prepare?

Some cultural competence issues were addressed. It was important for me to understand Paula's Catholic background. While Paula claimed that religion was not a big part of her life, her Catholic views did affect her decision to keep her pregnancy. They were also intertwined in her thoughts and feelings about death and dying.

There were also aspects of Paula's Latino culture that played out in her case. For example, her tendency to give up on mainstream medical interventions and resort to more holistic and home remedies is consistent with Latino culture. In addition, Paula was always resistant to involving outsiders (i.e., community resources, friends, aides, etc.) in her care/life. She held onto the cultural belief that family issues should be dealt with from within. What made this difficult for Paula was the fact that her family was not involved in her life. She did not want to rely on outsiders, but she was alone and really had no choice.

7. What local, state, or federal policies could (or did) affect this case?

The local and state policies that affected this case include Medicaid, WIC, New York State public assistance, New York City court system, and hospital policies such as length of stay, the Health Insurance Portability and Accountability Act of 1996 (HIPPA), coordination of care across disciplines, etc.

8. How would you advocate for social change to positively affect this case?

This does not apply to this case.

9. Were there any legal or ethical issues present in the case? If so, what were they and how were they addressed?

The big ethical issue that was present in this case was Paula's decision to keep her baby. Several of Paula's doctors held strong feelings that Paula should abort her pregnancy. They felt she was too ill to care for an infant and a child at all. As her social worker, I was not sure what the right answer was. It really did not matter because the decision was hers. My role was to support whatever decision she made and help her reach the best outcome given either scenario.

With regard to legal issues, Paula did obtain a restraining order for the baby's father. Throughout the course of treatment, the father violated the order once. I helped Paula file a report with the police regarding the violation. We also made sure that Paula's advance directives were in order and helped Paula file permanency planning paperwork with the courts. When working in a hospital setting, one must always deal with HIPPA and protected health information.

10. How can evidence-based practice be integrated into this situation?

Evidence-based practice can be integrated into the situation by using appropriate scales to measure depression, such as the Beck Depression Inventory-II, and by using formal suicide assessment, such as the Beck Scale for Suicide Ideation.

11. Is there any additional information that is important to the case?

There is no additional information.

12. Describe any additional personal reflections about this case.

Paula's case is one of the most difficult cases I have encountered in my career. I worked with Paula for a little bit over a year. We terminated because I left my position at the hospital. Paula not only challenged my social work skills, but she also drew me into her case emotionally. Yes, I was Paula's social worker, but at times I felt like I was her only friend and her caregiver. At the beginning, I felt an enormous sense of responsibility for the outcome of her situation. Paula consumed a lot of my time. She called me often and required a great deal of hand-holding. The irony is that when I did not hear from her, I worried. When I did hear from her, I felt like she was demanding and she drew me right into the chaos of her life and her situation. Eventually, when I realized the extent of my emotional involvement in this case, I had to set boundaries for Paula and myself. This became crucial to our work together. I ultimately realized that the boundaries were actually good for Paula as they demonstrated structure and the limitations of others' involvement in her life. They forced Paula to take personal responsibility for her situation and take an active role in dealing with it. For me, the boundaries kept me sane. They allowed me to realize my own limitations. Many times, I reminded myself, "You can lead a horse to water, but you can't make them drink."

I feel very fortunate that I was able to work with Paula as part of an interdisciplinary team. Working on a team allowed me to consult with colleagues about the direction we should take with Paula. It also helped me cope with the stress and challenges of Paula's case. My colleagues and I often found ourselves venting our frustrations, concerns, and fears with each other. I truly do not think I would have been as successful as I was in helping Paula if I had been on my own.

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