Parent blaming in child protection and health settings

A matter for concern

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This article is about parent blaming. It draws on the authors' experience in health care agencies and the children's court. Parent blaming involves practitioners attributing to parents an 'excess' level of responsibility expressed as 'blame' in regard to child care and protection or child treatment issues in the context of health. In the course of this process, structural factors such as low income, poor housing, unemployment, social isolation and prejudice that affect a parent's capacity to protect and care for a child are frequently ignored.

Parent blaming is not a new phenomenon although currently it seems to be in vogue among practitioners in these fields. When blame is conveyed to parents, it creates anger and resentment and guarantees a non-cooperative response from them. This response is then all too readily used as evidence to support the view that parents are indeed to blame for their child's lack of safety or medical condition. In practice, a blaming approach is futile. Suggestions are made about how this phenomenon can be avoided and how more positive approaches can be adopted to providing services to children and their families.

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Parent blaming is a process by which professionals, e.g. doctors, nurses, teachers, social workers and others, find fault with the care and nurturance being provided by parents for their children. In the last decade or more, the parent blaming phenomenon has been noted as an issue in relation to work with the parents of youth in residential programs (Ainsworth 1991), in child abuse and neglect cases (Reder, Duncan & Gray 1993; Scott & O'Neil 1996), as well as in relation to parents of emotionally disturbed children (Ainsworth & Hansen 2000; Johnson, Renaud, Schmidt & Stanek 1998). Feminist writers have also commented on parent blaming, particularly mother blaming in family focused therapeutic services (Allan 2004; Holten 1990).

All forms of parent blaming result in the pathologising of family life and the censure of parents in regard to their child rearing practices. When practitioners function from a parent blaming position, responsibility for a child's problems, difficulties or condition in all areas of development are all attributed to poor parenting and this limits consideration of other influences or explanations. In fact, parent blaming reflects a narrow and limited understanding of the tasks of child protection and health practitioners. It focuses on the process of identifying and punishing guilty or 'bad' parents as the major task in child protection and health settings. In doing so, parent blaming runs the risk of working against the key responsibility of protecting children from harm.

In contrast, a focus on family assessment and the creation of a therapeutic alliance with parents based on empathy and understanding offers an alternative practice strategy to ensure the safety and care of children. This approach also reflects the core social work values of respect for person, acceptance, non-judgmental attitudes, right to self-determination and confidentiality for parents as clients (Biestek 1961; Timms 1983).

EXPLANATIONS THAT LEAD TO PARENT BLAMING

Parent blaming has a long history. In the past parents and families have been blamed for a range of conditions experienced by their children. It is now known that much of this blaming was both unkind and untrue. For example, in a classic paper, Bateson (1956), an anthropologist, and Jackson, Haley and Weakland, all eminent psychiatrists and family therapists, put forward a theory of schizophrenia

based on the concept of 'double bind'. Double bind refers to a 'contradictory multilevel multi-channel communication system which it was claimed occurs in families that spawn schizophrenic persons' (Berger 1978, p. xiii). As a theory it had a major impact on the treatment of schizophrenia. Moreover, as Berger (1978, p. xvi) points out, psychotherapists with this theory in mind 'went stalking for double-binding parents especially for schizophrenogenic mothers who they believed were parasitically feeding on their child'. In fact, this way of thinking had wide impact and the authors of this paper recall being taught this theory in the 1960s and 1970s by sincere social work educators. The theory was not, and is not, supported by empirical evidence and today there is a growing consensus that schizophrenia, to the extent to which it is understood, is the result of an imbalance of brain chemistry and is best treated with antipsychotic medication (APA 1994, 2004). The 'double bind' theory remains an awful example of parent blaming by professionals.

Parent blaming is counter-productive in all situations where behaviour change is an objective.

A later example from the 1960s, but one that had similar characteristics, is the ideas in the famous Laing and Esterson (1963) text, *Sanity, madness and the family*. They put forward a similar explanation and expanded on the idea that had originated with Bateson of schizophrenia as 'a voyage of discovery' (Isaac & Armat 1990, p. 25). They took the view that schizophrenia should not be viewed as a mental illness at all but as a rational response to living in an 'unlivable' and irrational family system. The authors of this paper also recall this book being recommended reading for social work students in the 1960s and 1970s. Again, this theory was not supported by empirical evidence and today Laing and Esterson's views are largely discredited. But for a while their views were popular and supported yet another round of parent blaming.

Other conditions such as childhood autism and anorexia nervosa have all provided fertile ground for theories that support the notion that these conditions have their origin in dysfunctional family patterns, including the mother-child relationship (Gerhardt 2004). However, new theories are emerging which suggest that brain chemistry that influences a child's capacity for empathy may be the critical cognitive factor in the aetiology of autism (Cohen 2005). Recent innovative work in Sweden is also pointing to a new explanation for anorexia nervosa that suggests that the condition is due to a physical malfunction of the brain (Bergh, Brodin, Lindberg & Sodersten 2002; Coulthart & Farrow 2004).

Interestingly, attachment theory, which has been profoundly influential in social work practice (Howe 1995; Howe, Brandon, Hinings & Schofield 1999), also has its origins in the same era as the Bateson and the Laing and Esterson formulation of a theory of schizophrenia. It was also shaped by a similar professional group of analytically oriented psychiatrists and family therapists. It emerged principally from Bowlby's writings about 'maternal deprivation' that he later formulated as attachment theory (Bowlby 1969, 1973, 1980). If attachment theory is used solely to attribute negative patterns of child-parent attachment, such as anxious or avoidant attachment, to deficits in parental performance, then it is misguided. In such cases it reinforces parent blaming and more particularly the blaming of the mother (Allan 2004; Holten 1990). This blaming can happen in spite of the available knowledge about temperamental differences in very young children and the effect of this on attachment patterns (Gerhardt 2004; Kagan 1989a). There is also new knowledge about brain chemistry and brain development (Gerhardt 2004; Kagan 1989b) that warrants attention when considering attachment patterns.

It can also be argued that parent blaming is currently reinforced by a neo-liberal political discourse (Webb 2006) as this emphasises individual social responsibility and limits collectivist solutions to social problems. This is a moot point since the more psychological explanations for parent blaming that are explored here have prospered in many different political climates.

RESEARCH ON ATTACHMENT THEORY

Regardless of its influence, attachment theory is at best 'soft science' given that the evidence to support the theory is not from empirical studies but from clinical practice. Indeed, some of the research evidence, contrary to the commonly held view, is that 'early experience does not cause later pathology in a linear way' (Sroufe, Carlson, Levy & Egeland 1999). Moreover, one of the few longitudinal studies of a sample of high risk and maltreated children in adulthood found substantial discrepancies between predictions based on early childhood assessment of attachment and adult relationship outcomes (Roisman, Padrón, Sroufe & Egeland 2002). Further studies confirm these results. For example, an early study reported a similar quality of attachment between adoptive and non-adoptive families regardless of whether they were non-racially or racially adopted children (Singer, Brodzinsky, Ramsey, Steir & Waters 1985). The same study noted that lack of early contact with a child was not predictive of anxious mother-infant attachment. In addition, Juffer and Rosenboom (1997) found that 74% of the adopted infants were securely attached to their adoptive parents irrespective of country of origin or whether these parents had biological children.

It is also argued that attachment theory holds across different social contexts and cultures although studies that demonstrate this are few (Posada 2004). The lack of empirical evidence also applies to attachment patterns in low income families given that most attachment studies are based on samples of middle-class western parents (Posada 2004). Finally, and fundamentally, there is a questioning of the taxonomy used in attachment theory (secure, avoidant, resistant and disorganised) (Main & Solomon 1986) in terms of whether attachment patterns are continuously or categorically distributed (Cassidy 2003; Fraley & Spieker 2003; Waters & Beauchaine 2003).

As a result of these studies, some distinguished social work scholars (Barth, Clea, John, Quinton & Thoburn 2004) argue that the current state of knowledge about attachment is too flimsy for professionals to use it as evidence of error in parents' child rearing practices. At the very least, social workers and others should be more tempered in their use of explanations based on attachment theory. This is especially important in child protection and health settings where social workers frequently work with low-income and culturally diverse families.

PARENT BLAMING IN SOCIAL WORK

Through neglect, as well as inconsistent and inappropriate interactions with a child, parents may be the source of some of a child's developmental difficulties. Parents may also exacerbate a medical condition, such as diabetes, by not maintaining a recommended treatment regimen for a child. This latter situation can be viewed as neglect. Case example A, a case drawn from a child protection setting, illustrates this point. Case example B, a case drawn from a health setting, illustrates a similar point. (Note: the names in the case examples are fictitious.)

JUDGMENT BEFORE ASSESSMENT

Gambrill (2000) identifies situations where there are fundamental misjudgments about parenting behaviours as stemming from errors of attribution and behavioural confirmation bias. The first error starts from the tendency to attribute the cause of parent behaviour to personal characteristics and to overlook environmental factors. The second error or bias involves the search for data that supports a favoured position and ignores data that does not.

It has been suggested that these errors are linked to the early stage of professional career development. The claim is that newly qualified workers, when faced with harm to a child, quickly adopt a child rescue position that undermines the importance of parents (Fox Harding 1991;VanderVen 1981, 2005). If this occurs, then the errors or biases that Gambrill (2000) identifies come into play. What then follows is a 'rush to judgment' about a particular situation, with parent blaming figuring prominently in the judgment.

Under these circumstances, a move away from parent blaming to a family-centred practice approach when carrying

CASE EXAMPLE A : Child protection case study

Amanda, aged 12, her mother, father and three sisters aged 5, 8 and 10 years, live in a family home near Brisbane airport. Father is an invalid following an industrial accident. Amanda's mother and father argue a lot. Mother is depressed and not coping well. She is constantly bad tempered and critical of the children.

Recently, the police found Amanda in Fortune Valley late at night. She was unkempt in appearance. When questioned, Amanda gave her name and address but refused to say why she was in Fortune Valley. Nor would she say how she got the clearly visible bruises to her left arm. The police took Amanda home where her mother immediately shouted at her. Father was silent. Mother quickly admitted that she had hit her daughter earlier that day and probably bruised her arm. Amanda had run out of the house after that happened.

The police notified the Department of Child Safety's 'Helpline' about Amanda's situation. The Department investigated and confirmed that Amanda had been abused. The mother feels the Department caseworkers did not understand her situation and blamed her for what happened. That has made her very angry as she was already feeling guilty about hitting her daughter. The family has not heard from the Department since that time.

CASE EXAMPLE B : Treatment case study

James is an 8-year-old child who lives with his mother in a privately rented apartment in an outer Sydney suburb. He has Type 1 diabetes. This requires twice daily insulin injections. There are also strict dietary rules to be observed.

James's mother is a single parent in her early thirties who lives on Centrelink payments. She is not very well organised as a person and has difficulty in coping with her growing son. Even though she is James's mother, she says she is too frightened to give James his injections. Fortunately, James has been taught to self inject and, even at 8-years-old, can do this responsibly. Sometimes he forgets the injections and he certainly avoids his diet in favour of junk foods which his mother buys to please him. This has meant that in the last 12 months James has been hospitalised 7 times because his blood sugar level was dangerously out of control.

The medical team is frustrated at their inability to get James's mother to help James to conform to his treatment plan. They feel she is neglectful of her son's health. They blame her for James's repeated admissions to hospital. The team leader is thinking about notifying the mother to the Department of Community Services because of this neglect. They think this may frighten the mother into being more active in monitoring James's health.

out assessment and intervention tasks is unlikely to occur (Scott & O'Neil 1996). In our view, these errors are not the exclusive preserve of new workers. They equally apply to experienced personnel, some of whom, possibly due to fatigue or burnout (Maslach & Leiter 1997), prefer to quickly judge rather than carefully consider alternative case explanations.

BUILDING A PROFESSIONAL ALLIANCE

Our concern about the adoption of a parent blaming attitude is that it does nothing to alter the case situation and simply does not work (Trotter 1999). Indeed, it makes matters worse since it removes the need for professionals to have empathy for parents or to think critically about a situation. Instead, they can dismiss the parents as hopeless and incompetent. This in turn reduces the possibility of building a therapeutic alliance (Bordin 1979; Horvath 2001) between the professionals and the parents in an attempt to resolve issues of safety and other problems or difficulties.

Social worker practitioners and other professionals build a relationship or therapeutic alliance (Bordin 1979; Horvath 2001) with parents as a tool to be used to facilitate behavioural change. This process is enhanced by knowledge about models of readiness for change and motivational techniques that support the change process (Miller & Rollnick 1991; Prochaska, DiClemente & Norcross 1992). For practitioners, the alliance is also used as a vehicle for the delivery of support services that aim to sustain any achieved change. In addition, social worker practitioners uniquely add to these efforts through a concern about resource provision to reduce social and environmental pressures that inhibit healthy family functioning. Overall, the aim is to use the therapeutic alliance to provide the 'best mix of services' that enhance the well-being of families and children and maximise parental feelings of personal empowerment and self-esteem by reinforcing recently established changes (O'Connor, Wilson & Setterland 2003).

The key components of the therapeutic alliance in psychotherapy have been defined as the 'collaborative and affective bond between therapist and patient' (Martin, Garske & Davis 2000: 438). There is also wide acceptance in these circles that the therapeutic alliance is a major factor in explaining client changes (Brown & O'Leary 2000; Johnson & Wright 2002; Martin, Garske & Davis 2000; Van der Feltz-Cornelis et al. 2004). This is supported by a recent meta-analysis of published and unpublished studies (Martin, Garske & Davis 2000) that found a moderate, but consistent, effect of therapeutic alliance on outcomes such as symptom reduction and subjective assessments of change in individual coping capacity.

Usefully, the therapeutic alliance has been defined as 'the development of bonds, the assignment of tasks and the agreement on goals' (Horvath 2001). This is a definition that echoes writing from an earlier era about task-centred social casework (Reid & Epstein 1972). It is very likely that the moderate but consistent effect of therapeutic alliance found by Martin, Garske and Davis (2000) on symptom reduction and of change in coping capacity would also be found following interventions in relation to parental treatment compliance and in parenting practices in child protection situations.

Of course factors that may affect the quality of the therapeutic alliance include demographic variables of both worker and client (Burkard, Juarez-Huffaker & Ajmere 2003), length of service (Howgego et al. 2003; Lorentzen, Sexton & Hoglend 2004), case difficulty (Colson et al. 1991) and the skill level and experience of the worker (Werner-Wilson et al. 2003). There is limited research on other possible predictors. Saarnio (2000) reviews the literature on the therapists' personal qualities and efficiency in practice. Horvath (2001) identifies interpersonal skills and the psychological makeup of the therapist as factors affecting the alliance. Horvath and Symonds (1991, cited in Werner-Wilson et al. 2003: 383) state:

> the relationship of working alliance to therapy outcome does not seem to be influenced by type of treatment, length of treatment, or number of participants.

THE PURPOSE OF EMPATHY

As noted, the three components of the therapeutic alliance – 'the development of bonds, the assignment of tasks and the agreement on goals' (Horvath 2001) – are vital considerations. The first component raises questions about the role of empathy (Corey 2005; Macdonald 2001; Rapp 1998; Wampold 2001) in the establishment of a 'bond' between a social worker and a parent. Empathy is 'the capacity to fully comprehend' the experience of another person, in this instance a parent. While there never can be acceptance of child abuse, in the authors' opinion, the more there is an understanding about why abuse or neglect occurred, the more accurate the assessment is likely to be. In addition, empathetic understanding acts as a barrier against the adoption of a parent blaming position. And this is very important if there is to be effective intervention.

The establishment of a bond enhances the social worker's ability to reach an agreement about the other two components of the therapeutic alliance, that is, identifying jointly the tasks to be addressed and goals of any intervention. Given that an intervention in protective and treatment situations is about creating safety for a child or reducing the potential for treatment neglect, this is highly desirable. Of course, this does not mean that practitioners should ignore what parents may have done, or excuse them for doing things they should not have done. Parents must carry this cost as an acknowledgment of error and this can be a powerful motivating factor towards reducing the potential

for a reoccurrence of abuse or neglect. Without a therapeutic alliance, no matter how modest this may be, there will be no accepted assignment of tasks or agreement about the goals to be achieved. As a result, an effective social intervention is unlikely.

ASSESSMENT FIRST

In situations where an alliance has not taken shape and professional workers are frustrated by an inability to achieve change in relation to a child's problems or difficulties, it is very easy to slip into parent blaming. One way to guard against this is to have clear work structures through which to make an evidence-based assessment of parent and child functioning. This requires a careful bio-psycho-social and ecological approach (Department of Health 2000a, 2000b; Cohen, Hornsby & Priester 2005) that enhances our understanding of the case situation. An initial step in such an assessment is to return to an alliance building strategy and to undertake a comprehensive examination of the parents' living situation and those factors that shape the parent and child situation.

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Such an assessment is made in order to enable the professional worker to gain an understanding of which factors limit a parent's ability to safely care for and nurture a child – factors such as poverty, inadequate housing, unsatisfactory interpersonal relationships and other elements that can generate performance inhibiting levels of anxiety and stress. For a health team, treating an acute childhood illness, e.g. diabetes or asthma, these may be the factors that result in a parent's inability to comply with a child's treatment regimen including diet, exercise or medication. There is also need for an assessment of the parents' emotional and intellectual capacities, cultural and religious beliefs, as well as the relationship dynamics within the family, as all of these factors impact on parental behaviours. An assessment should guide the development of an intervention to change a situation to a child's advantage.

A social assessment is not a forensic investigative process where the purpose is to establish parental innocence or guilt. A full evidence-based social assessment addresses the complex range of bio-psycho-social and ecological issues that affect family life and allows for a clear picture to emerge as to where the introductions of family support or educational services may protect a child in the future. Providing services that ensure a child's safety and that support their long term in-home development is of more value than the prosecution of parents and the removal of a child to out-of-home care (Spratt & Callan 2004).

FAMILY STRESS, COPING AND ADAPTATION

An important feature of any assessment of parent and child functioning is in relation to family stress. Stress has many sources – social, psychological, economic and environmental – which include factors such as low income, poor housing, unemployment, social isolation and prejudice. Regardless of parental ability, if stress levels are constantly high, or are suddenly raised due to an unforeseen event, a parent's ability to attend to a child's needs and maintain a positive child-parent relationship can be severely disrupted. Awareness of parental stress levels is essential when considering issues of abuse or neglect or when there is a concern about the maintenance of a treatment regimen.

Well functioning parents display high self-esteem, confidence in their ability to meet the needs of their children and the ability to manage stressful life events, rather than being overwhelmed by them. They report well on measures of communication skills and problem solving (McCubbin, Thompson & McCubbin 1996; McCubbin, Thompson, Thompson & Futrell 1999). McCubbin and his colleagues have also identified family hardiness and the existence of family traditions and rituals as factors contributing to family resilience. All of these features sum to a healthy parental capacity for coping and adaptation in the event of an unexpected event or crisis.

Coping and adaptation processes are based on experiences in their family of origin, observation of others or learned as a result of dealing successfully with such events or crises in their actual family in the past. This process is exemplified in the double ABCX model of adjustment and adaptation (McCubbin & Patterson 1983) which emphasises the potential for positive or negative effects as a result of multiple stressful events. Even with established coping patterns, a more severe crisis may disrupt the normal family pattern of coping and adaptation. In such conditions, a parent's stress level may rise so high that for a limited period it is not uncommon for external assistance to be needed. Often, this is when social work services are sought. At its simplest level, the help needed may involve financial assistance but it may also involve intensive social and psychological counselling over many weeks.

When parental stress is constantly high due to severe social, psychological, economic or environmental factors, the ability to cope and adapt to new circumstances may be

severely limited. For example, living on a low income, in poor accommodation, in a constantly conflicted relationship and in a crime ridden neighbourhood may considerably diminish parenting capacity (Weatherburn & Lind 2001). In turn these factors affect parental self-esteem and confidence in the ability to respond to the protection and treatment needs of a child.

Yet parents who have to cope with these conditions are sometimes subject to the 'blaming' process by professionals who choose to discount the constant stressful conditions under which some people are forced to live difficult lives. Living in stressful, poor and unsafe neighbourhoods understandably makes it more difficult to complete parenting tasks adequately. Moreover, how such conditions shape the child-parent 'attachment relationship' remains, as Posada (2004) noted, largely unexplored.

SUMMARY

This article has drawn attention to the phenomenon of parent blaming by practitioners. Parent blaming is counter-productive in all situations where behaviour change is an objective. It may also be unethical since parent blaming is the product of uncritical practice that is not evidence-based (Gambrill 2000), as well as running contrary to core social work values (Biestek 1961; Timms 1983).

The 'therapeutic alliance' is the centre of effective social work intervention that seeks parental change. Once in place, an alliance provides the opportunity to develop a full social assessment of a family situation. The assessment then provides a framework for and gives direction to further social work intervention. Empathy is a tool to be used in the therapeutic alliance building and assessment stages. Later social work interventions should aim to motivate parents to revise or change their child care and child rearing practices. Interventions are many and can include parenting programs, relationship building workshops, as well as other educational programs, individual and family counselling, family day care and the acquisition of a range of resources that sustain family life. When parents are parties to a therapeutic alliance, and a sound family assessment and carefully planned interventions are in place, parent blaming can be avoided. Only then are a child's safety and treatment needs likely to be met. ■

REFERENCES

APA—*see* American Psychiatric Association

Ainsworth, F. & Hansen, P. (2000) 'Social workers' views of parents of emotionally disturbed children: Replicating a US study', *Australian Social Work*, 53, 3, 37-44.

Ainsworth, F. (1991) 'A "no blame" approach to work with the families of children and adolescents in residential care', *Child and Youth Care Forum*, 20, 5, 301-311.

Allan, J. (2004) 'Mother blaming: A covert practice in therapeutic intervention', *Australian Social Work*, 57, 1, 57-70.

American Psychiatric Association (1994) *Diagnostic and statistical manual of mental disorders (DSM - IV)*, Washington: DC.

American Psychiatric Association (2004) *Practice guidelines for the treatment of patients with schizophrenia*, 2nd edn, Washington: DC.

Barth, R.P., Clea, T.M., John, K., Quinton, D. & Thoburn, J. (2004) *Beyond attachment theory and therapy: Towards sensitive and evidence based practice principles and practices for services to foster and adoptive families*, paper presented at the Fourth International Seminar on 'Outcome-based evaluation in child and family services – Cross-national research initiatives', September, Abano Terme, PD: Italy.

Bateson, G., Jackson, D.D., Haley, S. & Weakland, S.H. (1956) 'Towards a theory of schizophrenia', *Behavioural Science*, 1, 251-264.

Berger, M.M. (ed.) (1978) *Beyond the double bind: Communication and family systems, theories and techniques with schizophrenics*, New York: Brunner/Mazel.

Bergh, C., Brodin, U., Lindberg, G. & Sodersten, P. (2002) 'Randomised controlled trial of a treatment for anorexia and bulimia nervosa', *proceeding of the National Academy of Sciences*, 99, 14, 9486-9491.

Biestek, F. (1961) *The casework relationship*, London: Allen and Unwin.

Bordin, E.S. (1979) 'The generalisability of the psychoanalytic concept of the working relationship', *Psychotherapy, Theory, Research and Practice*, 16, 252-260.

Bowlby, J. (1969) *Attachment and loss, Vol. 1: Attachment*, New York: Basic Books.

Bowlby, J (1973) *Attachment and loss, Vol. 2: Separation, anxiety and anger*, New York: Basic Books.

Bowlby, J (1980) *Attachment and loss, Vol. 3: Loss, sadness and depression*, New York: Basic Books.

Brown, P. & O'Leary, D. (2000) 'Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse', *Journal of Counseling and Clinical Psychology*, 68, 2, 193-197.

Burkard, A., Juarez-Huffaker, M. & Ajmere, K. (2003) 'White racial identity attitudes as a predictor of client perceptions of cross-cultural working alliances', *Journal of Multicultural Counseling and Development*, 31, 4, 226-244.

Cassidy, J. (2003) 'Continuity and change in the measurement of infant attachment: Comment on Fraley and Spieker', *Development Psychology*, 39, 3, 409-412.

Cohen, D. (2005) 'Blame it on testosterone', *Australian*, Higher Education (p. 28), 12 January.

Cohen, E., Hornsby, D.T. & Priester, S. (2005) 'Assessment of children, youth and families in the child welfare system', in G.P. Mallon & P. McCartt Hess (eds.), *Child welfare for the 21st century: A handbook of practice, policies and programs*, pp. 87-101, New York: Columbia University Press.

Colson, D., Cornsweet, C., Murphy, T., O'Malley, F., Hyland, P., McParland, M. & Coyne, L. (1991) 'Perceived treatment difficulty and therapeutic alliance on an adolescent psychiatric hospital unit', *American Journal of Orthopsychiatry*, 61, 2, 221-229.

Corey, G. (2005) *Theory and practice of counseling and psychotherapy*, 7th edn., Belmont, CA: Thomson: Brooks/Cole.

Coulthart, R. & Farrow, N. (2004) *The Stockholm solution*, Channel 9, The Sunday Program, 31 October.

Department of Health (2000a) *Framework for the assessment of children and their families*, London: The Stationery Office.

Department of Health (2000b) *Assessing of children in need and their families: Practice guidance*, London: The Stationery Office.

Fox Harding, L. (1991) *Perspectives in child care policy*, London: Longman.

Fraley, R.C. & Spieker, S.J. (2003) 'Are infant attachment patterns continuously or categorically distributed? A taxometric analysis of strange situation behavior', *Developmental Psychology*, 39, 3, 387-404.

Gambrill, E. (2000) 'The role of critical thinking in evidence-based social work', in P. Allen-Meares & C. Garvin (eds.), *The handbook of social work direct practice*, Thousand Oaks, CA: Sage Publications, pp. 43-63.

Gerhardt, S. (2004) *Why love matters: How affection shapes a baby's brain*, London: Brunner-Routledge.

Holten, J. D. (1990) 'When will mother blaming stop?', *Journal of Feminist Family Therapy*, 21, 1, 53-60.

Horvath, A. (2001) 'The therapeutic alliance: Concepts, research, research and training', *Australian Psychologist*, 36, 2, 170-176.

Howe, D. (1995) *Attachment theory for social work practice*, London: Macmillan.

Howe, D., Brandon, M., Hinings, D. & Schofield, G. (1999) *Attachment theory, child maltreatment and family support*, London: Macmillan.

Howgego, I., Yellowlees, P., Owen, C., Meldrum, L. & Dark, F. (2003) 'The therapeutic alliance: The key to effective patient outcomes? A descriptive review of the evidence in community mental health case management', *Australian and New Zealand Journal of Psychiatry*, 37, 2, 169-183.

Isaac, R.J. & Armat, V.C. (1990) *Madness in the streets: How psychiatry abandoned the mentally ill*, New York: Free Press.

Johnson, H.C., Renaud, E.F., Schmidt, D.T. & Stanek, E.J. (1998) 'Social worker's views of parents of children with mental and emotional difficulties', *Families in Society: The Journal of Contemporary Human Services*, 79, 2, 173-187.

Johnson, L. & Wright, D. (2002) 'Revisiting Bordin's theory on the therapeutic alliance: Implications for family therapy', *Contemporary Family Therapy*, 24, 2, 257-263.

Juffer, F. & Rosenboom, L.G. (1997) 'Infant-mother attachment of internationally adopted children in the Netherlands', *International Journal of Behavioural Development*, 20, 93-107.

Kagan, J. (1989a) 'The idea of temperamental types', in J. Kagan, *Unstable ideas: Temperament, cognition and self*, Cambridge, MA: Harvard University Press, pp.107-142.

Kagan, J. (1989b) 'Inhibited and uninhibited children', in J. Kagan, *Unstable ideas: Temperament, cognition and self*, Cambridge, MA: Harvard University Press, pp.143-175.

Laing, R.D. & Esterson, A. (1963) *Sanity, madness and the family*, London: Tavistock Publications.

Lorentzen, S.H., Sexton, H. & Hoglend, P. (2004) 'Therapeutic alliance, cohesion and outcome in a long-term analytic group: A preliminary study, *Nordic Journal of Psychiatry*, 58, 1, 33-40.

Macdonald, G. (2001) *Effective interventions for child abuse and neglect*, Chichester: Wiley.

Main, M. & Solomon, J. (1986) 'Discovery of a new insecure-disorganised/disoriented attachment pattern', in T.B. Brazelton & M. Yogman (eds.), *Affective development in infancy*, Norwood, NJ: Ablex, pp.95-124.

Martin, D., Garske, J. & Davis, M.K. (2000) 'Relation of therapeutic alliance with outcome and other variables: A meta-analysis review', *Journal of Consulting and Clinical Psychology*, 68, 3, 438-450.

Maslach, C. & Leiter, M.P. (1997) *The truth about burnout. How organizations cause personal stress and what to do about it*, San Francisco, CA: Jossey-Bass.

McCubbin, H.I. & Patterson, J.M. (1983) 'The family stress process: The double ABCX model of adjustment and adaptation', in H.I. McCubbin, M. Sussman & J.M. Patterson (eds.), *Social stress and the family: Advances and developments in family stress theory and research*, New York: Haworth Press.

McCubbin, H.I., Thompson, A.I. & McCubbin, M.A. (1996) *Family assessment: Resiliency, coping and adaptation. Inventories for research and practice*, Madison, WI: University of Wisconsin Press.

McCubbin, H.I., Thompson, E.A., Thompson, A.I. & Futrell, J. (1999) *The dynamics of resilient families*, Thousand Oaks, CA: Sage.

Miller, W.R. & Rollnick, S. (1991) *Motivational interviewing: Preparing people to change addictive behaviour*, New York: Guilford Press.

O'Connor, I., Wilson, J. & Setterland, D. (2003) *Social work and welfare practice*, 4th edn., Sydney: Pearson Education.

Posada, G. (2004) 'Through Columbian lenses: Ethnographic and conventional analyses of maternal care and their associations with secure base behavior', *Developmental Psychology*, 30, 4, 508-518.

Prochaska, J.O., DiClemente, C.C. & Norcross, J.C. (1992) 'A search of how people change: Application to addictive behaviour', *American Psychologist*, 47, 1114-1202.

Rapp, C.A. (1998) *The strengths model*, New York: Oxford University Press.

Read, W.J. & Epstein, L. (1972) *Task centered casework*, New York: Columbia University Press.

Reder, P., Duncan, S. & Gray, M. (1993) *Beyond blame. Child abuse tragedies revisited*, London: Routledge.

Roisman, G.I., Padrón, E., Sroufe, L.A. & Egeland, B. (2002) 'Earned-secure attachment status in retrospect and prospect', *Child Development*, 73, 4, 1204-1219.

Saarnio, P. (2000) 'Does it matter who treats you?', *European Journal of Social Work*, 3, 3, 261-268.

Scott, D. & O'Neil, D. (1996) *Beyond child rescue*, Sydney: Allen and Unwin.

Singer, L.M., Brodzinsky, D.M., Ramsey, D., Steir, M. & Waters, E. (1985) 'Mother-infant attachment in adoptive families', *Child Development*, 56, 1543-1551.

Spratt, T. & Callan, J. (2004) 'Parents' views on social work interventions in child welfare cases', *British Journal of Social Work*, 34, 2, 199-224.

Sroufe, L.A., Carlson, E.A., Levy, A.K. & Egeland, B. (1999) 'Implications of attachment theory for developmental psychopathology', *Development and Psychopathology*, 11, 1-13.

Timms, N. (1983) *Social work values: An enquiry*, London: Routledge Kegan Paul.

Trotter, C. (1999) *Working with involuntary clients*, Sydney: Allen and Unwin.

Van der Feltz-Cornelis, C., Van Oppen, P., Van Marwijk, H., De Beurs, E. & Van Dyck, R. (2004) 'A patient-doctor relationship questionnaire (PDRQ – 9) in primary care: Development and psychometric evaluation', *General Hospital Psychiatry*, 26, 2, 115-120.

VanderVen, K.D. (1981) 'Patterns of career development in group care', in F. Ainsworth & L.C. Fulcher (eds.), *Group care for children: Concept and issues*, London: Tavistock.

VanderVen, K.D. (2005) 'Patterns of career development in group care', in L.C. Fulcher & F. Ainsworth (eds.), *The best of group care practice* (forthcoming), New York: Haworth.

Wampold, B.E. (2001) *The great psychotherapy debate: Models, methods and findings*, Mahwah, NJ: Lawrence Erlbaum Associates.

Waters, E. & Beauchaine, T.P. (2003) 'Are there really patterns of attachment? Theoretical and empirical perspectives', *Developmental Psychology*, 39, 3, 417-422.

Weatherburn, D. & Lind, B. (2001) *Delinquent-prone communities*, Cambridge: Cambridge University Press.

Webb, S.A. (2006) *Social work in a risk society: Social and political perspectives*, Basingstoke: Palgrave.

Werner-Wilson, R., Michaels, M., Gellhaus Thomas, S. & Thiesen, A. (2003) 'Influence of therapist behavior on therapeutic alliance', *Contemporary Family Therapy*, 325, 4, 381-390.