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# COMPASSION: THE NECESSARY FOUNDATION TO REUNIFY FAMILIES INVOLVED IN THE FOSTER CARE SYSTEM

Katherine Markey and Vivek Sankaran

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Compassion plays a critical role in ensuring that stakeholders can engage with, and support parents trying to reunify with kids in the foster care system. This Article will explore the compassion crisis in foster care, will present the research documenting the impact of compassion on engaging families, and will identify key steps stakeholders can take to incorporate compassion into their work.

## Practitioner's Key Points:

- To learn the research proving that compassion can help professionals engage with and support families.
- To identify the ways in which the foster care system falls short on practicing compassion.
- To explore practices professionals can incorporate into their work to practice compassion.

**Keywords:** *Child Welfare; Compassion; Family Engagement; Foster Care; Parents.*

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Our client's husband died suddenly of a heart attack, after three years of marriage. His sudden death devastated her. She fell into a deep depression and self-medicated by drinking alcohol in copious amounts. She drank so much that she struggled to parent her five-year-old son. One day, after a morning spent drinking, she passed out and was unaware that her son had wandered outside. The police found the child at a local convenience store and called Child Protective Services, which filed a petition in juvenile court requesting that the child be placed in foster care.

The court granted the request, put the boy in foster care, and required the child welfare agency to provide services to reunify the family. Over the next year, the agency offered services to the client – parenting classes, substance abuse treatment, a parent mentor, to name a few. But nothing worked, and our client kept drinking. Roughly two years after the family had been separated, the court terminated her parental rights. After we were appointed to represent her on appeal, we asked her why she had given up. She said she felt hopeless and believed no one truly cared about her or her pain.

Our client's case highlights the enormous task child welfare professionals face. First, they must determine whether the alleged abuse or neglect of a child requires the intervention of agencies and courts. Next, if such intervention is necessary, they must develop a strategy to try to keep the family together, and when separation must occur, to reunify children with their parents. Thus, our work involves both a *historical element* – did something happen to necessitate intervention? And a *forward-looking element* – how can we help the family address any concerns and heal? These obligations are embedded in federal law, which requires child welfare agencies to make reasonable efforts to both prevent the entry of children into foster care and to reunify a family if children enter care.<sup>1</sup>

In thinking about what reasonable efforts entail, professionals typically focus on which concrete services to offer parents. Did the agency tailor the service plan to meet the needs of the family?

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Were those services provided in a timely manner? Did the service plan identify specific ways to overcome any barriers the parents face? These questions – aimed at determining whether the agency made reasonable efforts – focus on the material items provided to the parent to address their shortcomings.

This mindset, focusing on the concrete services provided to a family, misses an important element. In addition to thinking about the “reasonable efforts” requirement as simply an evaluation of *what* efforts were made, we must also consider *how* those efforts were provided. In that latter analysis, this Article argues that compassion – which is rooted in empathy – must be the foundation for all reasonable efforts. So long as the child welfare system fails to incorporate principles of compassion and empathy in its work with families, no effort it makes to reunify the family will be reasonable.

Our client’s story vividly illustrates this point. The child welfare agency attempted to fulfill its reasonable efforts obligation by providing a plethora of services to her after placing her child in foster care. But at no point did anyone – her caseworker, lawyer, judge, or anyone else – show her the compassion she needed. No one noticed or acknowledged the pain she was experiencing from the loss of her husband or helped her process that loss. Instead, professionals labeled her an alcoholic, prescribed a plan for her to comply with, and watched as she struggled.

Without showing her compassion, it was unreasonable for the system to expect her to succeed. In other words, even when we provide the “right” services, the absence of compassion makes it far more difficult for many families to succeed. Robert Ashford, a recovery scientist at the Center for Studies of Addiction at the University of Pennsylvania, put it bluntly: “When we treat people like dirt, we can’t expect them to build rapport with professionals or to engage in their progress.”<sup>2</sup>

This Article discusses the critical role compassion must play in child welfare proceedings. Part I outlines the unique nature of child welfare proceedings, which involve both adjudicating historical facts and also motivating parents to engage with professionals to address ongoing concerns. It also highlights how families feel about their experience with the system and the ways in which the system struggles to show compassion. Part II looks at research from the medical field on how compassion can be instrumental in helping clients move forward in addressing their own needs and explains why child welfare professionals must learn from that research, given the parallels between the two fields. Finally, Part III makes specific recommendations on how child welfare professionals can incorporate this research into their practice and make compassion the foundation for all of their efforts. While this Article focuses on how professionals must work with parents involved with the system, its recommendations equally apply to working with others in the system, including children, foster parents and relatives.

## I. THE COMPASSION CRISIS IN CHILD WELFARE

As noted above, child welfare systems have a unique framework. First, courts and agencies must ascertain whether facts in a particular case necessitate a need for state intervention. If so, then professionals within both systems – for example, caseworkers, judges, and attorneys – must work with the family to address the areas of concern to attempt to keep children from entering foster care, or to get kids in foster care homes in an expedited matter. Thus, unlike most legal systems that focus exclusively on adjudicating historical facts, the child welfare system has a critical forward-looking component. It must actively partner with families to keep children connected with their families.

Data, however, suggests that the system struggles to effectively partner with families. In 2018, approximately 264,000 children entered the foster care system.<sup>3</sup> Of those, the overwhelming majority of children entered the system due to neglect or substance abuse issues, not serious physical or sexual abuse.<sup>4</sup> In other words, there is good evidence to believe that most cases do not involve the type of horrific evidence of maltreatment to suggest that reunification is not a plausible goal for the family.

Yet the system only successfully reunified children with their families in 49% of all cases.<sup>5</sup> And even when these children went home, they still spent an average of ten months in foster care.<sup>6</sup> This data raises questions about whether our system is effectively working with families to maximize the possibility of reunification.

These inadequate outcomes are unsurprising, given the sentiment shared by many parents that professionals within the system are not effectively working with them because they do not understand their needs or the trauma they have experienced. According to the National Child Traumatic Stress Network (“NCTSN”), “many birth parents involved with child welfare services have their own histories of childhood and/or adult trauma” which has serious consequences for children, adults, and families.<sup>7</sup> For example, research indicates that 30–60% of maltreated children have parents who have experienced domestic violence themselves.<sup>8</sup> Consistent with this, it is not uncommon for advocates to report that many parents in the system have their own histories of mental illness, abuse as a child, and homelessness, or that the parents have spent time in the foster care system. According to the NCTSN, these traumatic events in childhood and adolescence can continue to impact the lives of parents, affecting their ability to regulate emotions, maintain their health, engage in relationships, parent effectively, and maintain family stability.<sup>9</sup>

The system itself can exacerbate this trauma to parents by stripping them of control of their children. “[I]t is not uncommon for the court setting or legal process to trigger feelings of helplessness or loss of control in parents, which may be exacerbated by the parents’ past trauma and its reminders.”<sup>10</sup> After kids are placed in foster care, parents report that they are not invited to participate in school meetings, doctor’s appointments or administrative meetings concerning their child. At a time when they are already experiencing pain, the system’s response only makes it worse.

This pain is compounded when professionals in the system do not understand or acknowledge the trauma they have experienced. Recently, the federal government interviewed parents as part of their review of state child welfare systems. During those interviews, parents reported that “[n]othing was personalized” and that they were “scared to share information about [their] past because it seems we will be penalized for it.”<sup>11</sup> Similarly, parents felt like they lacked a voice in the process and that caseworkers needed “more training/experience about what it [was] like to be a parent involved in the system or a parent struggling with addiction.”<sup>12</sup>

Researchers analyzing feedback given by parents during a federal audit reached similar conclusions. Researchers found that parents felt that caseworkers focused more on compliance with services than on addressing their needs.<sup>13</sup> They “felt talked over and judged” and noted that the case service plan was often already completed before they even saw it.<sup>14</sup> In doing so, one parent felt that “the worker made assumptions about his needs” and felt stereotyped.<sup>15</sup> Another remarked that “getting to know the family [was a] very important piece that seems to be missing” and that [caseworkers] “seem to treat every parent who comes through the system as a drug addict when not all parents are drug addicts.”<sup>16</sup>

In short, parents felt “powerless,” and expressed that “at the very lowest point in your life ... they come in and hit you where it hurts and you don’t have a leg to stand on.”<sup>17</sup> Compounding this problem, they described “that no one [was] in their corner [and there was] no one to explain what just happened.”<sup>18</sup> The report concluded that they did not “feel supported at all because they [were] scared.”<sup>19</sup>

These comments typify how many parents in the child welfare system feel about the process. They feel unheard, powerless, and ignored. They feel like no one truly listens to them and understands their needs. They feel that their trauma and pain go unaddressed. In the words of our client, they feel “hopeless.” So long as parents continue to feel this way about the child welfare system, they will not meaningfully engage with agencies and courts.

The next section details the medical research on compassion, demonstrating that compassion can be a powerful antidote against hopelessness. It can serve as an effective tool to help parents invest in their own recovery and connect with those professionals – caseworkers, judges and attorneys – tasked with helping them.

## II. COMPASSION – THE ANTIDOTE TO HOPELESSNESS

### A. FINDINGS FROM MEDICAL RESEARCH

Medical research has documented how compassion can be an effective tool to combat hopelessness and a powerful way to get patients to invest in their treatment. Showing compassion begins with empathy. Empathy is defined as “a predominantly cognitive ... attribute that involves an understanding ... of [the] experiences, concerns and perspectives” of another individual.<sup>20</sup> Empathy requires both the ability to take on someone else’s perspective and to communicate that you understand. Researchers of empathy have reduced the concept of empathy into a simple, straightforward measure: a physician is empathetic when patients feel he or she knows them as a whole person.<sup>21</sup> Compassion takes empathy and operationalizes it. While empathy requires recognizing the emotions of another, being compassionate means feeling motivated to act to alleviate suffering.<sup>22</sup>

Research documents the strong correlation between compassionate doctoring and improved adherence to treatment by patients.<sup>23</sup> For instance, researchers found that when physical therapists working with elderly patients were more empathetic, their patients were more likely to do their prescribed exercises at home.<sup>24</sup> Similarly, multiple studies have also found a link between doctor empathy and treatment adherence in HIV patients. Researcher Mary Catherine Beach posed a simple research question: whether patients living with HIV/AIDS who answered “yes” to the question, “does your doctor know you as a whole person?” would better adhere to their treatment regimens.<sup>25</sup> The question was designed to measure “patient-centeredness,” or a doctor’s ability to practice empathy and compassion to understand each patient as a unique person.<sup>26</sup>

Beach’s research specifically looked at the patients’ adherence with Highly Active Antiretroviral Therapy (“HAART”).<sup>27</sup> HAART treatment consists of taking a cocktail of antiviral drugs tailored to each patient. The efficacy of the treatment requires that patients are regimented and careful about taking their medication daily.<sup>28</sup> The treatment can be difficult, causing a number of challenging side effects that can impact a patient’s daily life.<sup>29</sup> Among the more than 1500 patients surveyed, adherence to the HAART treatment increased from 67% to 76% when patients reported that their doctor knew them as a person.<sup>30</sup>

Another researcher, Tabor Flickinger, also examined HIV patients, conducting hour-long interviews with them to assess their perceptions of their physician’s empathy and compassion and their treatment adherence.<sup>31</sup> Flickinger’s research provides insight into why there is such a strong correlation between physician empathy and treatment adherence in the HIV/AIDS context. Clinicians who displayed greater empathy empowered patients to disclose more information in their appointments.<sup>32</sup> When physicians engaged with patients more, using positive talk and asking more questions, patients in turn “gave more information to their clinicians in both the psychological and biomedical realms.”<sup>33</sup> With more information, treatment could be more tailored to suit the patient’s needs, allowing for better treatment and treatment adherence.

Across the medical field, there is a crisis in treatment adherence; studies show that about half of the medications for chronic conditions are not taken as prescribed.<sup>34</sup> But encouragingly, across a variety of medical contexts, empathetic interventions from doctors lead to better treatment adherence and patient self-efficacy.<sup>35</sup>

Because empathy by doctors improves treatment adherence, it also correlates to improved long-term health outcomes.<sup>36</sup> In Nalini Ambady’s research on physical therapy treatment adherence, the elderly patients with empathetic physicians saw improved abilities to complete the activities of daily living.<sup>37</sup> In contrast, for the patients whose physical therapists were not empathetic, they had both short and long-term decreases in the activities of daily living.<sup>38</sup> Similarly, the same HIV patients who were more likely to adhere to their HAART treatment saw improved health outcomes.<sup>39</sup>

Why does empathy work so well? Medical care requires trust and open communication between patient and physician, and physician empathy proves to be a simple way to foster both.<sup>40</sup> In a survey of 127 studies on the correlation between empathetic care and treatment adherence, researcher Kelly Zolnieriek extrapolated a key unifying feature: communication.<sup>41</sup> When physicians were able

to communicate well with their patients, their patients had 19% higher treatment adherence across a variety of medical contexts.<sup>42</sup> The benefits of communication between doctor and patient are straightforward; communication “improves the transmission and retrieval of important clinical and psychosocial information, facilitates patient involvement in decision making, allows open discussion of benefits, risks, and barriers to adherence, [and] builds rapport and trust.”<sup>43</sup> Physician empathy correlates to a better exchange of information, which leads to better interpersonal trust and a perception of physician expertise and higher patient satisfaction, which in turn leads to better compliance.<sup>44</sup>

Empathetic doctors also have patients with lower levels of stress and anxiety.<sup>45</sup> Researcher Rachel Weiss hypothesized that physician empathy would lead to a decrease in patient stress and anxiety in emergency room intake appointments.<sup>46</sup> Weiss recorded intake appointments and coded each time a patient expressed a negative emotion. Then, she coded whether the physician responded empathetically, neutrally, or unempathetically to the patient.<sup>47</sup> When Weiss measured patient anxiety before and after these intake appointments, the patients whose physician had responded empathetically reported a decrease in anxiety level.<sup>48</sup> Sophie Lelorain found a similar correlation in cancer patients. Lelorain reviewed 39 studies examining physician empathy in cancer care, finding a connection between physician empathy and “lesser psychological distress.”<sup>49</sup>

Given the clear benefits of physician empathy in the medical context, the obvious first question is, do doctors have time to be empathetic with each and every patient? The research suggests that empathetic interventions can be short and do not extend the length of an average doctor-patient interaction.<sup>50</sup> In Weiss’s study of physician empathy and patient anxiety in ER intake appointments, she found that when physicians responded empathetically to patient concerns, not only did it alleviate patient anxiety, but it also had no statistical impact on the length of the appointments.<sup>51</sup>

Researcher Linda Fogarty created two videotapes of a simulated patient and physician interaction, one of which had a 40 second empathetic intervention.<sup>52</sup> When cancer survivors watched the videos, those who watched the video containing the 40 second intervention reported a significant reduction in anxiety.<sup>53</sup> Not only are empathetic interventions short, they also correlate to fewer missed appointments.<sup>54</sup> In short, empathy does not require a significant restructuring of a doctor’s practice. All it requires is listening to the instances when a patient expresses “concerns, emotions, or stressors,” and responding with recognition and compassion.<sup>55</sup> These small interventions can lead to better communication and trust, which can free up time in the long-run by reducing the need to perform “rework” to correct misunderstandings.<sup>56</sup>

In addition to improving patient outcomes and reducing patient anxiety, when doctors are empathetic, it improves their own ability to cope with stress, increases their happiness and self-esteem, and makes them feel less pressed for time.<sup>57</sup> Empathy and compassion are “stress-buffering” emotions, meaning practicing compassion can make you better able to cope with your own stress.<sup>58</sup> More specifically, research shows that when an individual is empathetic and compassionate, receiving social support during times of stress is more beneficial and better reduces stress levels.<sup>59</sup> Because compassion can reduce stress, there is also a clear correlation between empathy and compassion and facing stress without becoming burnt out.<sup>60</sup>

Practicing compassion also improves long-term psychological well-being of doctors.<sup>61</sup> Participants in a study who performed a compassionate task saw improved self-esteem and happiness, as well as marginal decreases in the level of reported depression.<sup>62</sup> Increases in happiness in turn “engender a variety of positive life outcomes, includ[ing] improved mental and physical health, work life, and interpersonal relationships.”<sup>63</sup>

Practicing compassion also increases feelings of time affluence, which is the perception of how much time you have.<sup>64</sup> Researcher Cassie Mogilner hypothesized that even though helping others through empathy and compassion takes objective time (but not as much as we might think), it would increase people’s sense of time affluence.<sup>65</sup> She designed a study that compared wasting time, spending time on others, getting time back, and spending time on oneself.<sup>66</sup> Participants who gave time to help others reported feeling that they had more time than any others.<sup>67</sup> Mogilner reasoned that this increased time affluence came from the fact that helping others made participants have increased feelings of self-

efficacy.<sup>68</sup> Simply put, spending time on others made the participants feel “highly effective and capable,” which in turn made them feel energized and like they had more time moving forward.<sup>69</sup>

## B. RELEVANCE OF MEDICAL RESEARCH TO CHILD WELFARE

It is clear from the research in the medical field that when doctors are empathetic, it improves both their patients’ lives and their own lives. But can we really say that the same positive outcomes will occur if child welfare professionals focus on compassion? Although mapping the research from the medical context onto the child welfare context is not a perfect fit, there are striking similarities between the two fields. Just as a doctor must both diagnose a problem and then focus on improving long-term health of their patients, professionals within the child welfare system often do the same. They must first determine whether the family needs assistance and in what way, and then work to strengthen the family by making efforts to bring the family together by providing them with assistance. The outcome of a child welfare case depends largely on a parents’ ability to work with professionals and adhere to a treatment plan, just as health outcomes depend on the same.

Moreover, many of the barriers that can exist between a doctor and patient also exist between professionals and parents in the child welfare system. For example, in the context of HIV treatment, researchers often note the number of emotional barriers that stand in the way of the doctor and patient understanding and trusting one another. HIV is a stigmatized disease, and thus patients often perceive that their doctors will judge them for their condition.<sup>70</sup> Moreover, HIV patients frequently have “comorbidities” of mental health problems and a history of substance abuse.<sup>71</sup> Among the cohort studied in Beach’s research, there was a high rate of substance abuse and high levels of social stress.<sup>72</sup> In a study of lung cancer patients, researchers noted that patients exhibited a high level of guilt because they suffered from a “potentially self-inflicted illness,” exacerbated by their own history of smoking.<sup>73</sup> Across the board, the studies from the medical field show how empathy can break down these barriers and improve treatment. Similarly, as detailed in Section I, parents in the child welfare system often confront similar barriers, such as mental health problems, struggles with substance use, and guilt about their own behavior as a parent.

Moreover, there is evidence that just as doctors are missing opportunities to be empathetic with their patients, those who work in the child welfare context are failing to notice these opportunities as well.<sup>74</sup> One such example comes from Nancy Colon, a parent whose experience in the child welfare system shows how much room for improvement there is.<sup>75</sup> In her account in *Rise Magazine*, Nancy describes entering the child welfare system when she received a call from CPS that she needed to bring her five children in for a meeting. The purpose of the meeting was to determine if Nancy had failed to protect her children in the face of the abuse they suffered at the hand of their father, who was also abusing Nancy. After the meeting, Nancy’s children were taken away from her and put in four different foster homes before she truly understood what was going on. Without any notice, a CPS worker handed Nancy a copy of her treatment plan and asked her to sign it. Throughout her case, Nancy “never knew what to expect from the next court hearing or why [she] kept returning to court.”<sup>76</sup> Her attorney never took the time to explain it to her. Nancy was confused and felt like she had no voice. Her story, unfortunately, is not a rarity.<sup>77</sup>

One of the many problems highlighted in Nancy’s story is the fact that she was not given a chance to review – contribute to the creation of – her treatment plan before signing it. When a patient visits a doctor to discuss treatment, the patient should have the final say over whether to start a medication, undergo a surgery, or make a lifestyle change. In contrast, when a parent enters the child welfare system, they are not given a chance to reject a proposed treatment plan; it is simply thrust upon them. In Beach’s study of HIV patients and adherence to HAART treatment, she also found a strong correlation between physician empathy and a patient’s decision to start the HAART treatment in the first place.<sup>78</sup> HAART, as discussed above, is a difficult treatment that requires perfect adherence or it will worsen the patient’s condition, and it can cause challenging side effects. The correlation between patients choosing to start HAART treatment and patients who had empathetic physicians shows that

when a physician is compassionate, they can get their patients on board with a difficult treatment more easily. By approaching parents in the child welfare context with empathy and compassion, could we see a similar increase in adherence to treatment? We suspect that we will.

The struggles of a mother we represented in a TPR appeal who had lost parental rights to her two-year-old son illustrates the crisis of compassionate understanding in the child welfare context, specifically in developing treatment plans. Throughout the course of her three-year-long journey through the child welfare system, this mother struggled to adhere to her treatment plan. It required her to perform weekly drug screens, attend parenting classes, attend visitations with her son, go to therapy, and attempt to find stable housing and employment. A few months before the TPR hearing, she was showing huge improvement. She was in an in-patient drug treatment program where all of her services were in the same building and she had a safe, comfortable place to live. Examining the record, it is clear that the judge, foster care workers, and her own court-appointed attorney were all feeling hopeful.

But then everything changed. In an effort to transition her out of the in-patient program, the Department of Health and Human Services (“DHHS”) started giving her bus tickets and asking her to travel to different offices around Detroit to receive her services. In response, she was giving these bus tickets to other women in her program and skipping the appointments altogether. In the court record, there was only one narrative: this mother was exhibiting an inability to adhere to her treatment. She was unwilling to improve and did not deserve to get custody of her child. To the court, this mother had failed despite DHHS’s reasonable efforts.

After reviewing the record, we called the mother to ask her if she would have time to meet in Detroit so we could hear her side of the story. This mother had suffered a total of four heart attacks over the course of her case, so we began by asking about her health and well-being. She explained that her mobility was even worse than before. She said that for the past couple of years, walking more than a block or two had become very difficult for her. This fact was nowhere to be found in the trial court record.

In preparation for our meeting, we looked up her new address and looked for nearby libraries or restaurants where we could meet, thinking she could easily take the bus. To our surprise, her house was a ten minute walk from the closest city bus stop. We looked up some of the services prescribed by her treatment plan and started charting the course from her old in-patient treatment program to the various offices. Had anyone, her trial attorney, the DHHS workers, the judge, ever stopped to notice that each of these visits would require her to walk to the bus stop and walk between bus transfers? Had anyone asked her about her problems with mobility due to her health problems?

Rereading the record, we saw this mother’s decision to give away her bus tickets in an entirely new light. She was not necessarily exhibiting poor decision-making; this was not evidence that she was a bad mother. Those bus tickets were worthless to her, as she could not physically get to any of the appointments anyway. Giving the tickets away to other women in her program was not an act of defiance; it was an act of kindness. We wondered how different this woman’s ability to adhere to her treatment plan could have been if her attorney, the judge, or the DHHS workers had stopped to get to know her and understand her health problems. What if someone had paused and acknowledged the physical toll of her four heart attacks? What if in acknowledging her pain, she would have felt more comfortable trusting the court with the knowledge that she was struggling to get around? To us, this story reflects the direct link between the medical research on compassion and our ability in the child welfare system to improve outcomes for families by prioritizing compassion in our work.

### III. INCORPORATING COMPASSION INTO CHILD WELFARE WORK

To operationalize compassion into our child welfare work, the first lesson is to recognize that parents, like patients in a medical setting, are likely giving us many opportunities to help them. In a study of physicians interacting with oncology patients, researcher David Easter found that physicians missed 70% of the empathetic opportunities that patients provided.<sup>79</sup> Among the eight appointments recorded in this study, the patients gave physicians a total of 160 clear opportunities for empathetic responses.<sup>80</sup> Similarly, Diane Morse identified that among the 384 empathetic



opportunities provided by lung cancer patients, doctors missed 345 of them.<sup>81</sup> On its face, this research seems discouraging. But it can be reframed positively to highlight that patients – like the families in the child welfare system – are providing professionals *dozens* of opportunities in every interaction to respond with empathy and compassion. At the end of her research, Morse encourages doctors to practice some self-compassion when attempting to improve empathy. “Empathic responses can be brief and may not notably lengthen encounters,” and therefore, Morse reasons, “if empathic opportunities are not addressed physicians will get another chance and sometimes several more chances to respond empathically.”<sup>82</sup>

The lesson here is simple: demonstrating empathy does not require a total shift in a professional’s daily practice in meeting with parents and guiding them through the process. It simply requires paying attention to those moments where a parent brings up stress, emotion, and fear, and taking the time to pause and say, “I can imagine how difficult that is.”<sup>83</sup> It can also be helpful to develop a “compassionate script” of details that you share with a parent up front, making sure that they understand your goals and your intention to be a supportive advocate for them.<sup>84</sup> At a minimum, regardless of whether you are a caseworker, a children’s attorney or a parent’s attorney, this script should include your commitment to support the parent getting their child back, the specific steps you will take to do so, and your ability to keep their confidences a secret from others. After handling case after case, these details may seem as obvious to child welfare professionals as they are foundational. But empathy necessarily requires a recognition that while a professional is likely well-versed in the child welfare process, the parent likely is not. Assume that the parent does not know who you are, or what your role in the system is. Nor should you assume that they will think you are an ally in their journey to get their children. You must both tell and show them that you are.

Not only are parents giving us ample opportunities to improve, the literature from the medical field also suggests that adding empathy into a professional practice can be as simple as making small adjustments to words and gestures. In Nalini Ambady’s study of interactions between elderly patients and their physical therapists, she measured empathy not through the words of the therapists, but through their body language.<sup>85</sup> Specifically, Ambady coded for non-verbal cues from the physical therapists included “smiles, frowns, nods, head shakes, shrugs, forward leans, looks away, and sitting.”<sup>86</sup> When physical therapists exhibited “facial expressiveness” or active listening, which includes nodding and smiling, their patients had better health outcomes and treatment adherence in both the short-term and long-term.<sup>87</sup> The research suggests that a simple nod, a physical cue that we are listening to our clients and connecting with their struggles and pain, can improve their adherence to their service plans.

Another simple fix comes from adjusting our vocabulary to use words that imbue empathy rather than judgment.<sup>88</sup> In the child welfare system, parents often bring stigma with them, including the stigma of suffering from substance use disorders.<sup>89</sup> According to the Center for Behavioral Health Statistics and Quality, 28% of the individuals who do not receive or follow-through on treatment for substance use disorders report that stigma is a formidable barrier to engaging in care.<sup>90</sup> Researcher Robert Ashford studied the impact of the words we use to describe individuals seeking care for substance use disorders and how the vocabulary itself can affect the perceived bias and stigma.<sup>91</sup>

Ashford found that terms like “addict,” “alcoholic,” “relapse,” and “substance abuser,” all perpetuate stigma.<sup>92</sup> In contrast, replacing those negative terms with words that disassociate the person from the problem reduces implicit and explicit bias. For instance, referring to someone as “a person with a substance use disorder,” and replacing “addiction” with “recurrence of use,” empowers someone suffering and struggling to have an identity as a whole person beyond their condition.<sup>93</sup> When we “use stigmatizing, punitive language ... [such as] ‘dirty’ or ‘clean’ urine, ‘addict,’ ‘lush,’ ‘alcoholic,’ ... professionals view or see people with addiction as manipulative, less motivated, angry, violent.”<sup>94</sup>

By using language that suggests we recognize the humanity of those struggling, we open the door to their treatment. One way professionals can demonstrate compassion towards parents in the system is to carefully use words that convey that we fully recognize the humanity of each person who stands before us. For example, rather than refer to parents as “respondent” or “mom,” professionals could call them by their name. Rather than refer to a romantic partner as a “paramour,” professionals could

again refer to them by name, or by value-neutral terms like boyfriend, girlfriend, or partner. A simple test could be to ask ourselves whether we would want someone talking about our lives using those words. Applying that test, we might find the language professionals use in child welfare to discuss families to be insulting and demeaning. We can change this practice immediately.

In addition to using words that recognize the worth of each person in the child welfare system, child welfare professionals can ask themselves a series of questions to ensure that they are prioritizing compassion in their work. These questions are borrowed from researchers measuring compassion and empathy, who pose them to patients when determining whether doctors properly responded to a client's pain.<sup>95</sup> The questions, reframed for child welfare practice, are listed below:

1. Did I make the parent feel at ease by being friendly and treating them with respect?
2. Did I give the parent a chance to describe their situation in their own words without interrupting?
3. Did I pay close attention to what the parent was saying, not looking at my files or computer while they spoke?
4. Did I take an interest in the parent as a whole person, not just a case number? Did I get to know details about their life?
5. Did I communicate to the parent that I understood their concerns, not overlooking or dismissing them?
6. Did I show that I was genuinely concerned, connecting with the parent on a human level?
7. Did I have a positive attitude, being honest but not negative about problems at hand?
8. Did I explain things clearly, fully answering the parent's questions and giving adequate information about what was happening?
9. Did I explain to the parent in an encouraging way what they could do to improve the situation?
10. Did I discuss options with the parent, involving them in decisions and taking their views into account?

A major caveat of using a self-assessment is that the psychological literature suggests that the best measures of empathy are patient-centered; the measures that ask how empathetic a physician is from the patient's perspective.<sup>96</sup> So, we might also consider incorporating questions to parents into our professional practice. As child welfare professionals grow more comfortable with asking the questions of ourselves, we should consider asking parents for feedback as well. Asking these types of questions of parents will signal to them that our system truly cares about them as human beings.

Finally, in addition to using respectful words and asking the right questions, child welfare professionals must take steps to respond to a parent's pain. No matter what role one plays in the system, opportunities to show compassion exist. For attorneys, this might involve filing a motion or standing up for a client at a meeting or a hearing. For judges, it might mean allowing a parent to speak first at a hearing or making sure that court hearings are scheduled at a time convenient to families. For caseworkers, it might entail allowing a parent to draft a case service plan first, before the professional provide input. For agency directors, it might mean hiring system-involved youth and parents as key advisors who are integrated into agency decision-making. These are but a few ways in which compassion can guide our work. As the medical research shows, giving people an opportunity to feel heard can dramatically impact outcomes, while not taking any more of our time.

The words of Shrouda Selivanoff, a parent who lost her children to the foster care system and then regained custody, demonstrate the profound impact that compassion can have on the families in the system. She writes:<sup>97</sup>

Families involved with child welfare do not need to be fixed; they need to be healed. A healing approach recognizes that people are often overwhelmed by their circumstances and prioritizes their emotional stability. Crucial to this approach is acknowledging that circumstances are often out of a family's control and refusing to shame or blame parents in need. By granting dignity to a parent, we avoid creating more stressors and trauma for people who are already in crisis."

She concludes, “[I]t is also essential to fulfill their basic human need to experience compassion, understanding, and positive engagement. Recognizing and tending to families’ emotional needs, in my opinion, is more effective than providing concrete goods or funds.”<sup>98</sup> In other words, creating strong relationships – rooted in compassion – rather than simply delivering services might be the most effective way to support people and help them get back on track.

#### IV. CONCLUSION

Simply put, the research demonstrates that noticing and acknowledging the pain that parents are experiencing and taking some action to show them that we care about them as people can have a dramatic impact on outcomes. This type of compassion can reduce anxiety and stress, improve the ability of parents to engage with professionals, and even strengthen our capacity to sustain meaningful work in the field. Compassion can be a game changer.

But the challenge will be to incorporate these principles into practice. In the busyness of our practice, will we continue to overlook the pain parents share with us? Will we continue to proceed as if parents are not crying out for understanding and help? Will we continue to blindly believe that prescribing services to parents will be effective when they feel hopeless? These are the questions we must confront as we implement a paradigm shift that makes compassion the foundation for all of our efforts in the child welfare system.

#### ENDNOTES

1. 42 U.S.C. § 671(a)(15).
2. Elizabeth Brico, *The Real Harms of Abusive Stigmatizing Language in Addiction Treatment*, FILTER (2020) <https://filtermag.org/language-addiction-treatment/> (last visited June 24, 2020).
3. See U.S. Dep’t of Health and Human Services, Administration for Children and Families, *The AFCARS Report* (Aug. 22, 2019) <https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport26.pdf>.
4. *Id.* Federal data indicates that over 60% of cases involve neglect, while only 4% involve sexual abuse.
5. *Id.*
6. *Id.*
7. National Child Traumatic Stress Network, *Birth Parents With Trauma Histories And The Child Welfare System: A Guide For Child Welfare Staff* (2011) [https://www.nctsn.org/sites/default/files/resources/birth\\_parents\\_with\\_trauma\\_histories\\_child\\_welfare\\_child\\_welfare\\_staff.pdf](https://www.nctsn.org/sites/default/files/resources/birth_parents_with_trauma_histories_child_welfare_child_welfare_staff.pdf).
8. *Id.*
9. See National Child Traumatic Stress Network, *supra* note 8.
10. See *id.* at note 9.
11. United States Dep’t of Health and Human Servs., *Child and Family Services Review – Round 3 Findings* (2015–2016) [https://www.acf.hhs.gov/sites/default/files/cb/cfsr\\_round3\\_findings\\_2015\\_2016.pdf](https://www.acf.hhs.gov/sites/default/files/cb/cfsr_round3_findings_2015_2016.pdf).
12. *Id.*
13. United States Dep’t of Health and Human Servs., *Parent Engagement – Reflections from the CFSR: 2015–2017* at 4 (2019) [https://www.acf.hhs.gov/sites/default/files/cb/cfsr\\_parent\\_engagement\\_ad\\_hoc\\_report.pdf](https://www.acf.hhs.gov/sites/default/files/cb/cfsr_parent_engagement_ad_hoc_report.pdf).
14. *Id.* at 5.
15. *Id.* at 10.
16. *Id.* at 14.
17. *Id.* at 6.
18. *Id.* at 7.
19. *Id.* at 7.
20. Sophie Lelorain et al., *A Systematic Review of the Associations Between Empathy Measures and Patient Outcomes in Cancer Care*, 21 PSYCHO-ONCOLOGY 1255 (2012) (quoting Mohammadreza Hojat, *Empathy in Patient Care Antecedents, Development, Measurement, and Outcomes* (2007)).
21. See, e.g., Mary Catherine Beach et al., *Is the Quality of the Patient-Provider Relationship Associated with Better Adherence and Health Outcomes for Patients with HIV?*, 21 J. GEN. INTERNAL MED. 661 (2006).
22. Clara Strauss et al., *What is Compassion and how Can We Measure It? A Review of Definitions and Measures*, CLINICAL PSYCHOL. REV., 15, 25 (2016) (Identifying the five components of compassion as “understanding its universality; feeling

sympathy, empathy or concern for those who are suffering ... tolerating the distress associated with the witnessing of suffering; and motivation to act or acting to alleviate the suffering.”).

23. See, e.g., Nalini Ambady et al., *Physical Therapists' Nonverbal Communication Predicts Geriatric Patients' Health Outcomes*, 17 PSYCHOL. & AGING 443 (2002); Tabor E. Flickinger, *Clinician Empathy is Associated with Differences in Patient-Clinician Communication and Higher Medication Self-Efficacy in HIV Care*, 99 PATIENT EDUC. & COUNSELING 220 (2016); Meera Viswanathan et al., *Interventions to Improve Adherence to Self-Administered Medications for Chronic Diseases in the United States*, 157 ANNALS OF INTERNAL MED. 785 (2012); Kelly B. Haskard Zolnierrek & M. Robin DiMatteo, *Physician Communication and Patient Adherence to Treatment: A Meta-Analysis*, 46 MED. CARE 826 (2009).

24. Ambady, *supra* note 24, at 448–50.

25. Beach, *supra* note 22, at 661.

26. *Id.*

27. *Id.*

28. U.S. DEP'T OF HEALTH & HUMAN SERVS., *HIV Treatment Adherence*, AIDSINFO (Jan. 15, 2020) <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/21/54/hiv-treatment-adherence>, (describing the risk of drug resistance if patients do not adhere to treatment regimens).

29. U.S. DEP'T OF HEALTH & HUMAN SERVS., *HIV Medicines and Side Effects*, AIDSINFO (Oct. 24, 2019) <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/22/63/hiv-medicines-and-side-effects>.

30. Beach, *supra* note 22, at 61.

31. Flickinger, *supra* note 24, at 222.

32. *Id.* at 224.

33. *Id.* at 223.

34. Viswanathan, *supra* note 24, at 785.

35. *Id.* at 788.

36. See, e.g., Ambady, *supra* note 24; Beach, *supra* note 22; Flickinger, *supra* note 24.

37. Ambady, *supra* note 24, at 450.

38. *Id.* at 447.

39. Beach, *supra* note 22, at 661. Specifically, when a patient said their physician knew them as a whole person, they were more likely to have undetectable serum HIV RNA.

40. See, e.g., Sung Soo Kim et al., *The Effects of Physician Empathy on Patient Satisfaction and Compliance*, 27 EVALUATION & HEALTH PROFS. 237, 244 (2004).

41. Zolnierrek, *supra* note 24, at 832.

42. *Id.*

43. *Id.*

44. Kim, *supra* note 41, at 244.

45. Lelorain, *supra* note 21; Rachel Weiss, M.D. et al., *Associations of Physician Empathy with Patient Anxiety and Ratings of Communication in Hospital Admission Encounters*, 12 J. OF HOSPITAL MED. 805 (2017).

46. Weiss, *supra* note 46, at 805.

47. *Id.* at 806.

48. *Id.* at 807. Specifically, Weiss found that each additional empathetic response was associated with a 1.65 decrease in the STAI-S (State Anxiety Scale).

49. Lelorain, *supra* note 21, at 1257.

50. See, e.g., Linda A. Fogarty et al., *Can 40 Seconds of Compassion Reduce Patient Anxiety?*, 17 J. OF CLINICAL ONCOLOGY 317 (1999); Diane S. Morse M.D. et al., *Missed Opportunities for Interval Empathy in Lung Cancer Communication*, 168 ARCH INTERNAL MED. 1853 (2008); Weiss, *supra* note 46.

51. Weiss, *supra* note 46, at 808.

52. Fogarty, *supra* note 51, at 376.

53. *Id.*

54. Beach, *supra* note 22, at 661.

55. Morse, *supra* note 51, at 1855. (“The research evidence is clear that our actions create much of the patient demand that overwhelms us. When we treat symptoms and complaints, rather than root causes, our patients will always return for more ... [C]ompassionate care remarkably improves patient outcomes, dramatically reduces rates of interventions and costs, and helps our patients be more resilient.”).

56. Robin Youngson, *Practicing Compassion in an Uncompassionate Health System*, HEARTS IN HEALTHCARE (Sept. 1, 2017) <https://heartsinhealthcare.com/practising-compassion-in-an-uncompassionate-health-system/>.

57. See Brandon J. Cosley et al., *Is Compassion for Others Stress Buffering? Consequences of Compassion and Social Support for Physiological Reactivity to Stress*, 46 J. OF EXPERIMENTAL SOC. PSYCHOL. 816; Cassie Mogilner et al., *Giving Time Gives You Time*, 23 PSYCHOL. SCI. 1233 (2012); Myriam Mongrain et al., *Practicing Compassion Increases Happiness and Self-Esteem*, 12 HAPPINESS STUD. 963 (2011).

58. Cosley, *supra* note 58, at 821.

59. *Id.*

60. See Kandi Wiens & Annie McKee, *Why Some People Get Burned Out and Others Do not*, HARV. BUSINESS REV. BLOG (Nov. 23, 2016), <https://hbr.org/2016/11/why-some-people-get-burned-out-and-others-dont>.

61. Mongrain, *supra* note 58, at 977.
62. *Id.* at 976.
63. *Id.* at 977.
64. Mogilner, *supra* note 58, at 1233.
65. *Id.* at 1233.
66. *Id.*
67. *Id.* at 1235.
68. *Id.* at 1236.
69. *Id.* at 1233.
70. Flickinger, *supra* note 24, at 221.
71. *Id.*
72. Beach, *supra* note 22, at 663. Specifically, 43.5% of patients surveyed reported alcohol use in the past 6 months, 66.5% used cigarettes, and 24.1% used illicit drugs. In terms of social stress, only 47.6% of the patients were eating regular meals when they began receiving treatment.
73. Morse, *supra* note 51, at 1855.
74. See, e.g., David W. Easter M.D. & Wayne Beach PhD, *Competent Patient Care Is Dependent upon Attending to Empathic Opportunities Presented During Interview Sessions*, 61 CURRENT SURGERY 313 (2004); Morse, *supra* note 51.
75. Nancy Colon, *Afraid to Speak Up – I Needed My Lawyer to Be My Advocate*, RISE MAGAZINE (June 8, 2013), [http://www.risemagazine.org/backups/rise-old-website/issues/Rise\\_24/Afraid\\_to\\_speak\\_up.html](http://www.risemagazine.org/backups/rise-old-website/issues/Rise_24/Afraid_to_speak_up.html).
76. *Id.*
77. See, e.g., RISE, *Ask Yourself: 'Am I More Focused on Compliance than Safety?' – Parents Encourage Attorneys who Represent the Child Welfare System to Focus on Justice and Humanity in the Courtroom*, RISE MAGAZINE (Sept. 17, 2018), <http://www.risemagazine.org/2018/09/fcls-speech/>.
78. Beach, *supra* note 22, at 661. Specifically, 60% of patients who reported that their physician “knew them as a whole person” embarked on HAART treatment, whereas only 47% of patients chose to move forward with the treatment if they did not think their physician “knew them as a whole person.”
79. Easter, *supra* note 75, at 313.
80. *Id.* at 314.
81. Morse, *supra* note 51, at 1855.
82. *Id.* at 1856–57.
83. *Id.*
84. Youngson, *supra* note 57.
85. Ambady, *supra* note 24, at 444–45.
86. *Id.* at 446.
87. *Id.* at 448.
88. Examples of stigmatizing language used by child welfare professionals abound. Parents are referred to as “respondents.” Partners are called “paramours.” Fathers who are not “legal” are dismissed as being “putative.” Uses of these words further drive a wedge between families and the child welfare system.
89. See Robert D. Ashford et al., *Substance Use, Recovery, and Linguistics: The Impact of Word Choice on Explicit and Implicit Bias*, 189 DRUG & ALCOHOL DEPENDENCE 131 (2018).
90. *Id.* at 131. (quoting Center for Behavioral Health Statistics and Quality, *2016 National Survey on Drug Use and Health: Detailed Tables. Substance Abuse and Mental Health Services Administration*).
91. *Id.*
92. *Id.* at 137.
93. *Id.*
94. Elizabeth Brico, *The Real Harms of Abusive, Stigmatizing Language in Addiction Treatment*, FILTER MAGAZINE (Mar. 11, 2020), <https://filtermag.org/language-addiction-treatment/> (quoting Dr. Lipi Roy, a clinical assistant professor at NYU Grossman School of Medicine).
95. See, e.g., David P. Rakel et al., *Practitioner Empathy and the Duration of the Common Cold*, 41 FAMILY MED. 494 (2009).
96. Lelorain, *supra* note 21.
97. Shrouda Selivanoff, *Choose Compassion When Supporting Parents*, CHILDREN’S BUREAU Express (April 2020) available at [https://cbexpress.acf.hhs.gov/index.cfm?articleid=5537&event=viewArticles&issueid=215&utm\\_medium=email&utm\\_source=govdelivery](https://cbexpress.acf.hhs.gov/index.cfm?articleid=5537&event=viewArticles&issueid=215&utm_medium=email&utm_source=govdelivery).
98. *Id.*

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