Modes of Experience and Understanding: Parenting Assessment for Mothers with Serious Mental Illness and Child Protective Service Involvement

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Abstract

This chapter described and illustrated four modes of experience and understanding that comprise a parenting assessment for mothers with serious mental illness and child protective service involvement. The first mode introduces assessors to the immediate problems that led the child protective service to become involved with the family. The second mode seeks to understand how mothers' past experiences, their support networks, and mental illness have influenced their parenting and their ability to form and maintain relationships with others. The third mode provides information on children's attachment and developmental needs and on their experiences in being parented by their mothers. The fourth mode provides information from others who have known or treated the mother in different capacities. The assessment process involves a dialectical interplay of all four modes, each held in generative tension, each augmenting, confirming, and negating the others. Clinical illustrations are presented addressing different experiences and understanding gained from each individual mode. To formulate understandings in a new way, assessors must let go of preconceived ideas gained from one mode alone.

Tuesdays were elevator days. I walked from one building to the next, just before 8 am, through the courtyard and the glass doorways of the building into the foyer. Even at that hour, others were arriving too at the nine-story building: clients, mental health professionals, foster parents, caseworkers, and children of varying backgrounds and ages. When the elevator arrived, I entered, pressed the number 5, and waited as the doors closed. As the elevator started, I mulled over in my mind what I had read the evening before. The intake papers told me who would be arriving, what the mother's symptoms were, and why her children were in foster care.

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I was about to enter into an intense period of time where I would work with a multidisciplinary team to assess the parenting capabilities of mothers with serious mental illness who had lost custody of their children due to founded allegations of child maltreatment or risk of harm. I was part of the team, along with a psychiatrist and social worker. This chapter is about the women, their mental illnesses, about their parenting, and about assessments. I explore the idea that a parenting assessment is constituted by the dialectical interplay of four different modes of experience and understanding. They include the reasons why mothers became involved with child protective services in the first place, information about mothers' childhoods, mental illnesses, and support networks, and information about the children and from others who know the family in different capacities.

The stakes were high. Mothers we assessed had all lost custody of their children due to allegations of risk of harm or actual maltreatment. Their children had been living in foster care, often for a prolonged period of time. A legal decision now needed be made about whether interventions could ameliorate the risks in a time frame that made sense for the children, whether mothers could be immediately reunified with their children, or whether parental rights should be terminated. Erring on one side could contribute to mother and children being separated from each other forever. Erring on the other might contribute to child neglect, abuse, or risk of harm.

A developmental-clinical psychologist by training, my expertise was in children's well-being and development, psychopathology, and in bonds of caregiving and attachment. My tasks each week included meeting each mother individually and interviewing her about her children, her parenting, her childhood experiences, and her relationships with others. I observed her individually with each of her children and together as a group. I also asked mothers to complete various parenting questionnaires, then interviewed and observed each of her children, assessed their attachment and development, called foster parents, teachers, or grandparents, read records, and met with the psychiatrist and one or two social workers who were also on the team.

The team psychiatrist had expertise in how sex and gender influence the course, expression, and treatment of different psychiatric disorders. She also had expertise in assessing and treating psychiatric symptoms linked with female reproductive cycle transitions. This psychiatrist undertook a comprehensive psychiatric evaluation to make sense of the mother's symptoms, diagnose her, and to establish whether the treatment she was receiving was adequate for her condition. As part of this assessment, she interviewed each mother, obtained and read all available mental health records, contacted mental health professionals who were working with her or had known her in the past and in team discussions formulated how the mother's diagnosis and symptoms affected her parenting.

The team social worker started and ended the assessment process. As the team coordinator, she was the contact point for child protective services. She wrote up the referral notes, gathered records, maintained contact with the family, and visited the mother in her home to observe her in a natural setting with her children.

Our methodology emphasized the importance of observing mothers as they interacted with and parented their children. The methodology was also based in a review of all relevant information, past and present, we could gather on a mother's mental illness, her relationships with others, and on various facets of her parenting. In addition, we relied on both interviews and self-report measures and interviewed others about their observations and assessments. The methodology helped us to understand the impact of a variety of contexts (e.g., family, mental illness, environment and support, children) on parenting (Ostler 2008).

In our weekly meetings, team members brought in findings reflecting their areas of expertise. We discussed what each knew about a mother's parenting capabilities, past and present, and sought to understand the contributions of a mother's specific mental illness symptoms to parenting. We considered her insight into her illness (Mullick et al. Psychiatr Serv 52:488–492, 2001) and her responsiveness to and compliance with treatment. We looked at each mother's attachment experiences in childhood, how she formed and maintained supportive relationships, at stresses she was experiencing, and how her children were faring in their development and attachment.

The team met several times to discuss, analyze, and synthesize our findings about risk and resilience and to formulate recommendations. Each team member then composed an individual report summarizing their findings. The social worker also wrote a report synthesizing the team's findings on risk and protective factors and outlining recommendations for treatment.

This chapter describes the framework we used in our parenting assessment for mothers with serious mental illness and child protective service involvement. I explore and illustrate the idea that a parenting assessment is comprised of four modes of experience and understanding. The first mode involves the initial information about why a mother came to the attention of child protective services in the first place and why an assessment was needed. The second mode involves experiences with mothers: mothers' thoughts and feelings about parenting, their symptoms and mental illness, how they form and maintain relationships, and their feelings about themselves and each of their children. The third mode involves the children's attachment to and experiences with their mothers and how they are faring in their development. The fourth mode includes information from others who know mothers in different capacities.

I argue that the structure of the assessment involves a dialectical interaction between these four modes of information. Understanding results from ongoing discussions between team members, each of whom brings a different perspective and different knowledge base to the table. Part of this process involves identifying consistencies and discrepancies and actively coming to terms with biases, fears, or intrusive influences which could distort understanding. Another part involves tolerating uncertainty in order to formulate understandings in a different way.

Theoretical Approach

Before discussing each mode, I briefly review core theoretical premises from attachment, ecological, and violence risk prediction theories that undergirded the team assessment approach.

Attachment theory provides a rich basis for understanding the centrality of parenting, the bonds of love that bind parent and child to each other, and the reasons why a mother parents her children in the particular way she does (Bowlby 1988; Lyons-Ruth et al. 2005). This theory also provides a framework for understanding a child's attachment to his or her caregivers, how these bonds influence the child's ability to explore and to form relationships with others, and the effects of separation and loss on a child's bonds and his or her well-being (Bowlby 1988).

According to attachment theory (Bowlby 1988), the task of parenting is to protect a child from harm. As a child develops, a parent must be able to provide changing levels and forms of protection depending on the unique needs of each individual child as he or she develops (Solomon and George 2011). Parenting is made easier or more difficult depending on a mother's ability to form and maintain supportive relationships with others and depending on her ability to balance competing demands, including her own need for help.

Attachment theory also emphasizes that a mother's feelings for and behavior with her children are deeply influenced by experiences she has had and may still have with her own parents or caregivers. If a mother's own attachment needs were not met in childhood or if she was traumatized, she may feel helpless in the parenting role and may doubt that others will support her. In this context, she may turn to her child for support, ignore her child's needs as her own are so great, and/or may redirect anger at a child (Bowlby 1988). Current life stresses and the attitudes of a woman's partner are other important contributors to parenting.

Ecological theory provides a framework for understanding the dynamics of parenting breakdown and for isolating factors at various levels (individual, family, cultural, and societal) that contribute to parenting risk and competency. It underscores the influences of a variety of environmental and familial contexts that interact with each other over time to influence parenting (Belsky 1993). An important facet is the consideration the theory gives to protective factors that can ameliorate risk and promote more healthy parenting pathways (Cicchetti and Toth 1995).

Violence risk prediction research provides a theoretical framework for understanding when an individual with mental illness who has been violent in the past poses a substantial risk of harming others either currently or in the future (Steadman et al. 2000). It emphasizes the importance of assessing an array of empirical and theory-based risk factors in multiple domains of functioning, including a parent's own childhood experiences, their current disposition (anger, impulsiveness), and situations that could evoke risk behaviors. This theory also emphasizes the importance of looking at how specific mental illness symptoms, such as hallucinations,

delusions, or violent fantasies can lead to violence, as well as at the course and prognosis of the illness, and the individual's responsiveness to treatment. Risk is viewed not as something static, but as something that can change over time and in different contexts. A risk assessment involves an estimation of probabilities: how likely it is that harm will occur now or in the near future.

In the next sections, I describe and use clinical vignettes to illustrate the four modes and the assessment process. All case examples were modified to protect confidentiality.

The First Mode: The Referral

This mode of experience and understanding was initiated when a child protective service caseworker contacted the team social worker to refer a mother for an assessment. It included the reasons why the mother came to the attention of child protective services and a dialogue in which answerable questions were formulated that could bring the case and decision making further.

Caseworkers who referred mothers often expressed concern, doubt, anger, frustration, and apprehension during the first conversation. They were relieved that a team could assess the family, but often felt overwhelmed by the complexity of a case or wanted quick advice about how to proceed. Some viewed mental illness as something frightening or dangerous, something unpredictable that needed controlling. A few viewed mental illness as incompatible with parenting. Several could see potential for a mother to change or ways that she might be able to resume a parenting role. Others were skeptical or were uncertain about the effects a prolonged separation and stay in foster care were having on children. Some did not believe the mother had a mental illness or thought her symptoms had resulted only because of the custody loss.

The referral notes summarized information gained from the first referral call for team members. It provided critical, initial information: names of each family member, date of referral, time of the first appointment, and a formulation of the referring questions. These questions were unique for each family, but they usually involved questions about what the mother's psychiatric diagnosis was, what the optimal treatment was for her condition, how her symptoms had affected or could affect her parenting, what her children's individual needs were, what their attachment to their mother was like, and whether a mother currently could meet her children needs, or, if not, whether she could change in a time frame that made sense for her children.

This mode typically revealed mothers at a time of crisis. Mrs. O, woman with schizophrenia came to the attention of child protective services after she stopped taking her psychiatric medications. The team was called when the caseworker observed that she held her 3-month-old baby son so tightly that he would cry. Ms. W was also in crisis. Diagnosed with bipolar mood disorder, Ms. W became acutely psychotic after birth. At that time, she stated that she wanted to "kill everyone, even Jenny", her 7-day-old baby. Mrs. R had borderline personality

disorder, some traits of which can be associated with trauma. Her children were removed from her care after she attempted to take her own life by overdosing on pills. Mrs. N had had recurrent bouts of major depression. The child protective service agency was called after a neighbor reported that her 2-year-old had cuts and bruises on his face and body. The caseworker contacted the team as a deadline in court was approaching regarding termination of parental rights.

Reading each referral ushered in a sense of anticipation, but the content was also painful. While initiating an assessment, each referral also had the potential to contribute to over identifying with the caseworkers' viewpoint and to an early foreclosure of thinking.

The Second Mode: Mothers

My initial meeting with mothers began in the waiting room. I called out the mother's name and then introduced myself to her, her children, and to anyone else who had come, often a partner, a sibling, or foster parents. The meeting was both formal and personal. It was formal as I had not met the mother before. It was personal as I would spend the next hours with her and her children asking questions about all aspects of her life and observing her children.

Mrs. C was at the front desk when I met her for the first time. She showed little outward emotion and hardly looked at me. Mrs. R arrived for her assessment in the middle of winter. She was thin, had a black eye, and wore a thick winter coat. She looked very nervous as she hugged her six children who were gathered in the waiting room. She then had the children form a circle with her and holding hands, they prayed to the moon that they would be together soon in a new house. Mrs. R was currently homeless.

Ms. C had a different story all together. She became pregnant and voices had told her that the father was a famous football player. So she got on a bus, moved to the city he purportedly lived in, and became even more psychotic in the postpartum period. Her daughter was removed from her care at the hospital. When I met her, Mrs. C asked me if I was doing the "nesting assessment".

Almost all mothers showed great desire to resume a parenting role (Nicholson and Henry 2003). However, a few were ambivalent about parenting their child. Ambivalence was usually not easy to discern and was first evident in behavior. Ms. C, for instance, had two children. One was conceived by rape, the other from a man she loved. While stressing that she wanted to regain custody of both children, she only spent time with the child whose father she loved and ignored the other. Only over time did she tell me that she did not feel she could parent this child.

Mothers often had had painful and frightening experiences with caregivers in childhood. Some witnessed violent fights, were abused themselves, called names, were not wanted, or were left on their own for periods of time. Others were told they would be sent away. Several experienced sexual abuse or were parentified, taking care of both their own mother and siblings. Alternate caregivers were often absent. Mrs. R, a woman diagnosed with post-traumatic stress disorder who was frequently

sexually abused and experienced violence in childhood, sought comfort elsewhere. She recalled hiding in a closet and putting her head on an imaginary friend's lap when she was frightened. The friend said kind things to her and helped her fall asleep.

Some mothers had parents with serious mental illness or substance abuse problems. Some were raised by a grandparent, relative, or sibling or lived with foster parents. Some mothers described their own parents as critical, blaming, rejecting, unpredictable, or showing only intermittent care. These experiences contributed to women doubting that others would be there when they needed them, not only leading to constraints in confiding in others but also to attitudes of mistrust, anger, and to fears of separation (Bifulco and Thomas 2013).

Many mothers had come to minimize their need for support. Although they sometimes longed for support, they also insisted they were self-sufficient and could manage on their own. For some women, the support networks they had were impoverished or ephemeral. One woman noted that the bible was her only support. For some women, the main support was a grandmother who had died several years prior. Others listed individuals who had harmed them or their children as their main support.

The accounts suggested that the women's own attachment needs had been chronically or intensely activated in childhood but not assuaged (Solomon and George 2011). These adverse experiences made women more prone to be highly sensitive to stress, especially in the peripartum period, and more prone to develop unfavorable attitudes about parenting and to expect and demand care from their own children by inverting the parent–child relationship.

These women became overwhelmed when their own infants or children cried. Not being able to tolerate the cries, they left the room, hit the infant, or held their hands over their infant's mouth. The behavior of other women, however, was sensitive and responsive. One woman's daughter had been sexually abused in foster care. When her daughter became extremely distraught, the mother gently held her as she cried and was able to reassure her that she was there. Mothers who had been in therapy were learning to come to terms with traumatic experiences from childhood. They were often more able to put their children's needs first and were more able than other mothers to acknowledge their own imperfections as a parent.

Mothers' childhood experiences also influenced how they felt about and understood their own children. One woman who grew up in an orphanage relied on a rigid parenting routine that she had learned by rote in childhood. During our observation, she had her own children stand in a straight line and call out their name in turn. They then needed to march in order in a circle.

Women's parenting was also strongly influenced by their mental illness, illnesses that often had their origins in childhood or adolescence. For many women, symptoms emerged in the peripartum period, a period when women are particularly prone to either developing a mental illness or for experiencing symptom exacerbation (Miller 2002). Several women we assessed had become psychotic or depressed after giving birth to their baby, who was removed at birth.

The psychiatric evaluation helped the team psychiatrist to make sense of each mother's symptoms and to establish what disorder(s) she had. She established the mother's insight into her illness and her compliance and responsiveness to treatment, as well as whether she was receiving optimal treatment. If not, recommendations for treatment were made. In Ms. P's case, the evaluation revealed that her bipolar symptoms were linked to an underlying thyroid condition. The thyroid condition was treated and her symptoms decreased. By helping her to build her support network, Ms. P was able to resume a parenting role. Obtaining information on women's symptoms both from individuals who had treated them and from records was critical as some women denied any symptoms. The psychiatrist also looked at mother's mental illness symptoms in relation to their parenting trajectory.

A few mothers were extremely depressed or manic when they arrived for the assessment. One woman heard voices and talked with someone who was not there. All mothers had had at least one if not several recent psychiatric hospitalizations. Many women, however, had been taking psychotropic medication, and their symptoms had stabilized.

Home visits by the team social worker yielded yet a different perspective on parenting and on women's lives. It added critical contextual information that helped us to understand larger contexts that influence parenting, including the neighborhood and environment, mothers' support network, and life stresses. During one home visit, a team member came to understand why one mother had kept her toddler in a cardboard box, a claim that had contributed to the mother losing custody of her child. Not having the financial resources, the mother used the cardboard box as a substitute playpen so she could supervise her child's whereabouts as she cooked.

This mode, then, added a new layer to the assessment, providing a view into contexts that ameliorated or exacerbated parenting risk. Each team member obtained information on different contexts that could influence parenting, an understanding that was informed by each team member's expertise and training. My own training had taught me the strong influence that childhood experiences can exert on parenting, but the meetings also revealed the long-term influences that chronic, untreated mental illness and the environment can exert on parenting risk.

Anxiety experienced in this mode often came from unspeakable fears of losing custody of a child forever (Ostler 2012), an anxiety that was evident only in evasive answers, mistrust, but also in denial and minimization. This unspeakable fear was often present in women who had lost prior custody of a child. In some cases, it contributed to a denial of pregnancy (Miller 1990).

The Third Mode: The Children

Observations of and interviews with children added a different layer of depth and understanding to the assessment. Children who were assessed by our team had sometimes been separated only short periods from their mothers, but many had not

lived with their mother for months or even years. Some only knew their mother through visits as they had been removed at birth. Many wished to return home, but others were detached or wished to stay with foster parents. A few wished to be called by a different first name to escape into a new identity.

Children's attachment behavior is influenced by day-to-day experiences with a parent, but it is also strongly influenced by separations, something all children had experienced. During observations, many children hardly spoke with their mothers, averted eye contact, or called their mother by her first name, something that was often acutely painful to mothers. Others clung to their mothers and were unable to explore. Some older children completely adopted their mothers' perspective, and their own experiences were minimized. Many showed highly parentified behavior. One son whose mother had recurrent major depression arrived in time to help his mother with questionnaires and provided the psychiatrist with a full list of his mother's medication which he had carefully prepared. He supervised his siblings and brought them lunch. At the time, he was 11 years old. For others, the relationship with their mothers still had characteristic hallmarks of health, including an ability to use seek her out under stress.

Many children did not understand why they had been removed from their mother's care. Many blamed themselves for child protective service involvement. One 4-year-old girl constantly pinched herself in order to remind herself that she should be good. She believed that her own bad behavior had caused her mother to abuse her.

Some older children gave detailed account of experiences with their mothers, but their accounts were devoid of any personal feeling. Some of these children were highly controlling or shut down when asked about personal memories. Others, however, experienced anxiety states bordering on panic. Yet others provided fragments of information, or were unable, unwilling, or fearful to reveal more. Yet others gave a fantasized version of an idealized world that they wished to live in. These children appeared to have warded off extreme sadness, longing, and the pain of being alive by living in a state of non-experience (Ogden 2004a).

Children often came in with developmental delays, behavior and school problems, and a variety of psychiatric symptoms. Attention problems were common, but so was aggressive, angry, and helpless behavior. Several children hoarded. One small boy drank water all the time. Another soothed himself by sucking on his cheek. Some children revealed concerns they had about their own mental health, including worries that they might develop an illness like their mother's. Others showed resilience and were faring quite well. Nonetheless, children often put their own needs on a back burner and hoped for a time when life would be more normal.

Foster parents often provided a fount of information. Some had raised a foster child since birth. Others had only had the child for days or months. Foster parents varied in what they knew about children's individual needs, in their feelings about children and the children's mothers, and in how they cared for the children. Some wished to adopt a child.

The third mode exists in dialectical tension with the other modes. It provides a key perspective on a mother's caregiving abilities as it looks at how children have

fared, how they respond to her, what their attachment bonds are like, and how they are developing. This mode also provides critical information on a child's individual needs and allowed team members to assess whether a mother could meet these needs in a time frame that made sense for the child.

The Fourth Mode: Others

This mode included what we gleaned from pertinent records and what we learned from others who had known or knew the mother in different capacities over the years. Interviewing others was not always straightforward. Close relatives were often defensive or reluctant to say anything negative they had observed about parenting.

This was the case with Ms. B's sister. Ms. B had been diagnosed with schizophrenia. After the birth of her first child, her symptoms worsened when she went off of her medications. Although her sister regularly brought Ms. B food and diapers for her baby, she became concerned when Ms. B would not open the door and when she heard her 2-month-old niece crying in a weak voice. When I contacted Ms. B's sister, she was reluctant to say much, noting only that her sister loved her daughter. However, as we talked more and she came to understand the baby's needs, she was more open in sharing her concerns. The assessment ultimately helped Ms. B get into treatment. Some relatives, partners, and friends were forthcoming right away with their concerns. Some felt overwhelmed or burdened by the needs of a particular family and were frustrated by the mental illness, by a mother's lack of compliance with treatment, and/or by her struggles with parenting.

Interviews with others who knew mothers in different capacities forced us to look anew at our findings and the viability of the mothers' own accounts and at the accounts of others. In many cases, we found support for a mother's or caseworker's account, but in others the contradictions were glaring. One mother, for instance, claimed that she had gone outside for 15 min to buy food when her children were removed. Our interviews with others revealed a different story. The children, ages one and three, were left alone for over 10 h before protective services were called.

On one occasion, almost all initial evidence we heard from a caseworker was extremely positive. However, as we sifted through the evidence gained from other modes, it became clear that the caseworker had overidentified with the mother's position. The children's own reports and those who knew her well revealed substantial risks. The woman had broken off repeated contact with clinicians and acquaintances and continued to have serious mental health problems.

Records provided rich information about past observations or assessments and about functioning at over time. Some records provided detailed descriptions about parenting when it was at its best and at times when a mother was under stress. Others records were less useful. Behavior was labeled as good or bad, but no details were given about what happened or the context in which the alleged behavior occurred.

Mental health professionals brought additional perspectives to the assessment. Some had worked with mothers for years and had firsthand knowledge of her illness, her response to treatment, and how she cared for her children. Some had never seen a mother with her children or were unaware that she even had children. Some had observed a mother on only one occasion. One mental health professional noted that a woman who was acutely psychotic "should never parent," although the woman was highly responsive to medication and had good parenting skills.

The Assessment Process

The above four modes comprise the structure of a parenting assessment. The process of assessment involves looking at all four modes in their singularity and at once. It compares data from the different modes to identify both inconsistencies and patterns. It considers multiple viewpoints, suspends judgment, and is closely informed both by the expertise that each team member brings and by current research on mental illness, children, and parenting. The process involves close attention to ethical issues, transparency of practices, as well as an honest brokering of knowledge and uncertainties (Gambrill 2005).

Each mode engages a different perspective and yields different understanding, and each has its own validity and flaws. Drawing on one mode alone can lead to polarized views and will preclude a sound assessment of parenting competency and risk.

The assessment process involves a dialectical interplay of all four modes, each held in generative tension, each augmenting, confirming, and negating the experiences and understanding gained from the others. In this process, discussions move between the poles of the predictable and the unpredictable, the methodical and the intuitive, the disciplined and spontaneous (cf. Ogden 2004b, p 194). Through dialogue, this dialectical interplay between modes can then contribute to a more contextual, nuanced, and comprehensive understanding of parenting competency and risk.

The following clinical vignette illustrates the experiences and understandings gained from each individual mode and the understanding achieved by considering all four modes together. The case, described in detail in Jacobsen and Miller (1998), involved a 17-year-old mother with recurrent major depression. Ms. B came to the attention of CPS after she repeatedly hit her one-year-old daughter on the body and head over a period of several months, contributing to her daughter's death. Ms. B lost custody of a first child when she was convicted and had a second child in jail.

Reading just the intake papers could contribute to a highly negative view of Ms. B's parenting as her behavior had contributed to her child's death. However, when we interviewed Ms. B herself and learned about the circumstances surrounding the abuse, our perspective on maltreatment widened. Ms. B was a young woman caring for two children under age 5. Her daughter had feeding problems and often cried inconsolably. The beatings occurred in the context of overwhelming stress. Ms. B's partner drank and beat her regularly. Ms. B's only

support was her husband, but he was only intermittently present and also hit her when he drank. Her mother, who helped with Ms. B's first child, disapproved of Ms. B's partner and had maintained only sporadic contact with her daughter. Ms. B became depressed in this context and began hitting her child when her daughter could not stop crying or when she herself was hit by her partner.

The interview revealed that Ms. B was sexually abused in childhood. Her ability to form and maintain relationships with others was also largely inverted. While caring for others, she had a difficult time asking for help for herself. At the same time, Ms. B took ownership of parenting difficulties she had had and had good insight into her childhood experiences. She readily recognized circumstances that triggered her depression and had sought out treatment for her symptoms (Mullick et al. 2001). She was generally responsive to her children's needs except when overwhelmed.

Observing Ms. B's children added more depth to our understanding. The children enjoyed their mother's presence and readily sought her out for support. They both desired to return to her care, but also had developmental delays.

In interviews with therapists who had worked with her, we learned that Ms. B was highly motivated to change and was responding well to therapy. However, these sources also revealed that Ms. B maintained contact with her partner and continued to rely on his inconsistent support.

Nonlinear and dense, the assessment process looks at experiences and understanding gained from all four modes from a viewpoint of neutrality and objectivity as findings are analyzed and synthesized. In this process, it is necessary to suspend judgment and tolerate the experience of not knowing. To formulate understandings in a new way, assessors must dare to experience the tension of letting go of preconceived ideas gained from one mode alone.

Parenting assessments do not always lead to reunification. For some mothers, change may not occur in a time frame that makes sense for a particular child. Other parents, however, are able to resume a parenting role soon after an assessment or later (Jacobsen and Miller 1998).

Our assessments included recommendations that sought to address the individual concerns and needs of each mother, partner, and child, alone or together (Nicholson and Henry 2003; Ostler 2012). An assessment, then, was just the beginning of process that was aimed at furthering change and decision making. Rates of change and levels of motivation varied across mothers. When Ms. B, the young mother with depression who had killed her child, received feedback from our assessment, she completely broke off her relationship with her partner. With help, she continued to build a solid support network with family members and neighbors. When we reassessed her 6 months later, she was continuing to make steady progress in therapy and was about to regain custody of her children.

The term "assessment" can convey the idea that, in an assessment, a mother, partner, and child(ren) are relatively passive. However, if an assessment is to yield meaningful information, it should include active input from all participants. In an assessment, mothers, partners, children, and others expose themselves to considerable psychological strain. Assessors do as well, as they immerse themselves into a

person's life and history. Honoring the dignity of each person, knowing that this may not be synonymous with diminishing their pain, and striving to understand what constitutes risk and resilience in the face of complex and often disturbing emotional experiences are essential aspects of the process (Ogden 2005).

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