PRACTICUM

Creating Change with Families in the Child Welfare System: An In-Home Family Therapy Approach Utilizing Family Intervention Workers

by

© Adele McDougall

A Practicum

Presented to the Faculty of Graduate Studies

in Partial Fulfillment of the Requirements for the Degree

Master of Social Work

University of Manitoba

Winnipeg, Manitoba

1988

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CHAPTER I

INTRODUCTION

The purpose of this practicum was to offer a treatment program to child welfare families through a coordinated family therapy and in-home family support intervention. The intent was to provide a short-term intervention in order to improve family functioning and prevent the removal of children.

As I worked as a child welfare social worker, dealing with children both in their families and in care, I became aware of the lack of treatment options for families involved with such agencies. Although the children were the ones identified as at risk, many of the parents also suffered from abuse and neglect in their families of origin. The problems were almost always very deep-seated and multi-generational, and available resources rarely offered the intensity, frequency of contact, and specificity of treatment necessary to help such families learn new ways of interacting.

Treatment in Child Welfare

The child welfare system continues to be geared primarily towards children (hence, the name '<u>child</u> welfare') which often necessitates the identification of the child as 'disturbed', as being a 'problem' or as being sacrificed for the good of the family. Identification of the child as the problem is reflected in the use of terms such as 'oppositional' (Dadds, 1987) and 'conduct disordered' (Bunyan, 1987). Programs rarely go far enough into the family system to provide the change and support

required to improve family functioning and keep the family intact. Whittaker (1983) reports that service delivery in child welfare services is at a "social minimum level" (p.168). Although a variety of sources (Maybanks and Bryce, 1979; Bryce and Lloyd, 1981) suggest that truly family-oriented treatment seems to be one of the most effective interventions, it is not a widely available service.

Much of the money spent from child welfare budgets goes into substitute care (foster care, group homes, residential treatment). Resources are not readily available to treat the entire family even though the aim of child welfare agencies is to keep families together or reunite them if placement proves to be necessary (Cameron and Rothery, 1985). Rural child welfare agencies find that there are few treatment resources available, while the resources of city agencies are overbooked. Treatment for such families often consists of 'monitoring' a family and keeping a file open with little active therapy. Working within this system, I often felt frustration in not being able to offer any tangible service to change the family dynamics that led to abuse or neglect.

Traditional family therapists are not able to provide the intensive service required by these families. These families are often fearful and mistrustful of outsiders, particularly service providers with whom they may not have had positive experiences in the past. Family therapists do not have the luxury of spending many hours gaining a family's trust. The stressful environments

of such families (e.g. lack of physical resources, no money for transportation, no babysitters, inability to take time from work, being too exhausted after the day or immobilized by depression and hopelessness) are not conducive to attending in-office sessions.

Family Support

One of the most commonly utilized resources in child welfare is the family support worker. These are people who are sometimes employed by the child welfare agency but whose services are most often contracted from private agencies. These workers spend several hours per week with families, but most often spend their time with the child who is identified as a problem--taking them to movies or on other outings in order to provide positive experiences for the child and give them and the family a break from one another. However, the workers are rarely trained in a systems perspective or in family dynamics and are rarely supervised; even though they spend more time with the family than any other service-provider.

My past experience as a social worker at a residential treatment facility for children, under the age of twelve, identified as behaviourally or emotionally disturbed, offered me the opportunity to see the behavioural changes that occurred with the majority of children when stability and predictability were introduced into their lives. However, without treatment of their families, the children's behaviour quickly regressed when they were placed back at home. The regression emphasized the fact

that the problems of such children and the difficulties of such families were too entrenched to be ameliorated by simply treating the child or even by providing one hour per week of family therapy.

Following my residential experience, I had the opportunity to work in a program that offered intensive family therapy, supported by family support workers, in an in-home milieu. That year-long experience (prior to the practicum) convinced me that such a program could help families to make enough changes that they could graduate from being chronic child welfare 'cases'. Present-day philosophies talk about the desireability of empowering clients (Rothery and Campbell, 1985; de Shazer, 1985; Bunyan, 1987). In an in-home program, the family is approached on their own territory and treatment is very specific to their needs and their environment. I found it difficult to ignore pertinent ecological issues (such as poverty, lack of social support) when I became part of the world of particular families (and was able to view their world through their eyes) during in-home sessions. I experienced the family members' positive responses to my messages of their worth.

The Practicum

This practicum focused on the area of in-home treatment of families who are identified by child welfare as having difficulties in managing their children. The difficulties identified by child welfare ranged from abuse/neglect of young children, to parents who wanted their adolescent children removed

after years of escalating conflict. My efforts in the practicum were geared towards the design, development and implementation of a program of direct service delivery to such families.

Besides assessment, treatment planning and service delivery to client families, an added dimension of the practicum was working with the family support workers (referred to as intervention workers). This involved orienting workers to the philosophy of the new program and providing ongoing clinical supervision.

My educational objective was to learn about the issues involved in the treatment of families identified at risk by the child welfare system. I also hoped to offer a program to empower such families to begin to function interdependently with their own support systems.

Terminology

I have attempted to avoid labelling or blaming terminology as I write about the families with whom I worked. As one often finds when trying to change the words used to refer to familiar concepts, I experienced the pervasiveness of blaming, judgemental, negative terminology. Such terminology can be dehumanizing. Keeping this in mind, I have tried to follow the example of feminist therapists--who have made us aware of how language can be used to apportion blame; I have tried to avoid blaming language. As de Shazer (1986) writes, "For brief therapists their 'patient' is the *problem* (italics mine)..."(p.17). I have tried to work with the problem as the

focus of intervention, rather than seeing particular family members as being the problem. Once one member is identified as the cause of family difficulties, the family issues are no longer being seen in the light of systems theory. Taking a systems perspective of the problems arising in the lives of families identified by the child welfare system as in need of help was an aim of this practicum.

Terms such as; "home-based", "family-based" and "family-centred" are used interchangeably in the literature to refer to programs that work with families or that focus on home visiting. However, there are slight (and not so slight) differences between each of the terms. For the purposes of this program, I will use the term, "in-home" as it accurately and concisely describes the intended intervention.

I continue to try, but have found it more difficult to consistently employ a systemic perspective in reframing interactional dynamics. Here, I know that I revert to my narrower frame of reference and think in terms of 'problems', 'dysfunction', 'difficulties'; rather than 'solutions', 'coping strategies', 'creativity'...

Issues of Concern

I hoped that the following questions would be addressed in the course of this examination:

1. Would families labelled as 'resistant' (as so many on child welfare caseloads are) be reached by such a program model?

2. Would the intervention address issues that might have

resulted in the removal of children and thereby help to prevent family fragmentation?

3. Could the family support worker be trained to apply a systemic model/structural perspective to their work with families? Traditional family support workers are trained and supervised in a child specific model and would have to change their philosophy--an "epistemological shift" (Auerswald, 1987).

CHAPTER II

LITERATURE REVIEW

Since the 1970's, more information regarding in-home treatment of families identified as dysfunctional, has begun to appear in the literature (Bryce and Lloyd, 1981). Several authors (Kinney, 1977; Heying, 1985; Kaplan, 1986) see an increasing justification for such services based on their cost effectiveness as compared to more traditional child welfare services. However, much of the research leans to case descriptions, is anecdotal in nature, and has limited generalizability. Lack of controlled, sound methodological studies is the primary criticism made regarding family therapy research (Gray, 1980; Trute, 1985; Gelles and Maynard, 1987). The research literature regarding family support is also very unsatisfying. There are no definitions or descriptions of what such programs are intended to do or, in fact, actually do.

Nevertheless, the sevices continue to be available, although with recommendations from all quarters that more rigorous research be undertaken. This chapter will examine the treatment issues for families in the child welfare system and examine the in-home treatment and family support literature.

Child Welfare Families

Historically, the first discipline to actively focus on the issue of child abuse was the medical profession. As a result, the medical/psychiatric model has had a strong influence on both

research and treatment (Gelles and Maynard, 1987). The research continues to emphasize individual models and dynamics in the areas of child abuse and neglect, although the perspective is gradually changing (Trute, 1985; Brunk, 1987).

The majority of families who come to the attention of child welfare authorities do not come because parents have suddenly come to the realization that they no longer wish to care for their children. They come because physical disabilities, unemployment, poverty, divorce, poor living conditions, or mental ill health have reduced them to circumstances in which they, or the child welfare authorities, think that they are no longer capable of looking after their children (Bush and Goldman, 1982). Poor parenting is often the primary reason that service is required (Jones, Magura and Shyne; 1981). Jones (1976) reported that in nearly 80% of cases of the New York State Preventive Services Demonstration Project, which were identified as being in need of placement, the primary problem was "related to the functioning of the parents or to poor family relationships" (p.8).

Child welfare and family service departments put a far greater percentage of their resources into surrogate (i.e. foster care, institutional treatment) placement services than into family maintenance. Frankel (1988) discusses how the emphasis on ensuring the safety of children created a bias towards out-of-home care. As problems with out-of-home placement have become evident, the pendulum is swinging in the other direction.

Unfortunately, there is a dearth of research literature addressing the causal issues regarding the problems with which families come to the attention of child welfare agencies. Most child welfare workers and administrators are so busy dealing with day-to-day caseloads that they have neither the time nor the energy to look at the larger systems and the resulting impact of these systems on their clients. Whittaker (1983) discusses the concern that professional education and staff training are not keeping pace with the demands of current practice. Although seeing the child as a 'problem' is no longer the perspective of therapists and others involved with families in the child welfare system, the thrust of system itself does not reflect that viewpoint. With the child now being viewed as a 'symptom' of a larger family/systems problem (Auerswald, 1971; Minuchin, 1974; Coppersmith, 1985), child welfare, all too frequently, still takes children into care. The issue remains very clear that there is, generally, a great chasm between what is advocated by theorists and what is practiced by front-line workers. Bryce (1979) speculates that, because practitioners, program planners, and policy makers find little time to read, they are not implementing new programs such as family based ones.

Multi-Agency Families

The majority of families who come to the attention of child welfare agencies are identified as having multi-problems; both intra-familial and within their larger social context (Kaplan, 1986). Child welfare agencies are expected to serve the children

of these families when many other professionals and agencies have not succeeded. DeMaria (1985) points out that "such families are notoriously difficult to engage" (p.48). Many writers have used the term 'multiproblem' to categorize the nature of family dysfunction (Kaplan, 1986). McKinney (1970) reports the use of labels such as "hard to reach" or "hard core", but writes that "the term 'multideficit' more accurately characterizes these families" (p.327). This belief implies that the family has very few strengths upon which to build.

Reder (1986) describes a number of terms that have been used to describe multiproblem families: from "Minuchin's 'disorganized, pathological families'" (p.140) to "Aponte's 'underorganized'" (p.141). Such terms reflect more the perspective of the viewer rather than innate characteristics on the part of the family. Depending on when (stages in the family life cycle, or times of external crisis) or where (home, office, hospital) a family is being seen, the family attributes may differ. Families may appear to be displaying pathological behaviour when they are, in fact, acting out normal crisis reactions (Langsley et al., 1968; Golan, 1978).

Reder (1986) proposes that the term 'multiagency family systems' be used. This serves to emphasize the process rather then subjectively labelling such families from the viewpoint of the observer. Many families receiving service from child welfare agencies are simultaneously seeing other professionals, some (or all) of whom may be unaware of one another. Reder (1986) writes

that a "professional problem solver unwittingly can join the system [they are] trying to change and instead help retain its coherence" (p.141). Coppersmith (1982) writes about the role (inadevertant contributor to, or perpetuator) of family therapy in the dysfunctional patterns which may exist in the larger 'helping' system that may be involved with a family. In addition, Coppersmith (1983) discusses how outside helpers can often become 'one of the family', and, consequently, part of the problem.

The literature appears to contain a judgement that family dysfunction is directly correlated to the number of helpers involved. There is no acknowledgement that some of those helpers may be unhelpful, and that may be why the family seeks alternative assistance. A family may, in fact, have a single problem (i.e. a parent with low self-esteem). If they cannot meet the needs of their child, they may have a child welfare agency involved. They may be on welfare which impacts negatively on self-esteem. They may have received counselling from several sources perhaps because they either did not like the counsellor, could not afford the fee, the counsellor quit their job, or the family could not make regular appointments. If they have an acting out child; the school, the legal system, psychologists and /or psychiatrists may also be involved.

Rather than labelling the family as 'dysfunctional' or as having a 'deficit', it must be assumed that the family does have strengths (Bunyan, 1987) but that there are a number of areas,

both intra and extra-familial, in which the family requires some help (Brunk, 1987; Dadds, 1987). It, therefore, makes sense to assume that one method of intervention (i.e. solely family therapy or family support or parent-training alone) will not meet the needs of these families.

In-Home Treatment

In-home treatment, in the literature, is defined as any treatment program in which the therapists or caseworkers conduct some, or all, of their sessions in the client's home. There are many different programs: a one-time, treatment/assessment focused visit (Moynihan, 1974); moving in with a family (Hansen, 1968; Braverman, 1974); parent-training in the home (Worland, 1980; Campbell, 1983; Bunyan, 1987) as well as intensive intervention without living in (Sperekas, 1974; Kinney, 1977; Campbell, 1983; Lutzker, 1984). There are presently at least 180 home-based programs in the United States, which reflect a wide range of practice approaches (Frankel, 1988). Frankel (1988) describes that "family-centered, home-based services emerged in the early 1970's as one response to the movement away from institutionalization in mental health and child welfare services" (p.142).

The roots of social work practice, in the early twentieth century, lay with the family as the focus of casework. However, the mental hygiene movement and psychoanalytic theory shifted attention to the individual (Hartman and Liard, 1983). It became increasingly difficult, if not impossible, to integrate the

intrapsychic aspects of the individual (inner focus) with the outer focus of family and environment. Moynihan (1974) noted that home visiting is no longer advocated by social work practitioners, as it was in the early days of social casework. She suggests that the concept of 'friendly visitation' took on the connotation of an interfering busybody ready to pass judgement on the victim of the visit.

As professionals began to define the boundaries of their disciplines, the needs of the clinicians were served more by office visits (Sperekas, 1974). It is more convenient for the therapist to meet in-office; they don't waste time on travelling especially if the client cancels, more clients can be seen, the duration and content of the visit is more controllable in an office setting, the roles are more easily delineated--necessary when the therapist has the need to emphasize the power/authority relationship between themselves and the client.

On the other hand, the concept of going to a client's home in order to complete an assessment or provide treatment is one way to respond to the perceived 'resistance' on the part of the client, who, might otherwise not attend office sessions. Many programs argue that in-home treatment facilitates the assessment or treatment of otherwise unreachable families (Kinney, 1977). In-home treatment can be an effective response with a family that either does not have transportation to sessions or may be emotionally unable to engage in treatment in the office (Moynihan, 1974). Rothery and Fusco (1986) write that "continued

failure of mainstream family therapy models to come to grips with the clinical requirements of poor families" (p.64) indicate a reluctance to apply their techniques outside of the office. Families may be frightened or mistrustful of professionals, intimidated by office meetings, unable to schedule regular appoinments because of chaotic lifestyles or they may be fearful of the treatment process itself. However, in-home treatment contrasts with the view that home-visiting is a response to what may be seen as a deficit on the part of a client. In-home programs can also be beneficial for those families who are more amenable to in-office treatment (Braverman, 1974).

Underpinning the concept of in-home treatment is an ecological perspective. Individuals are viewed within the context of the interactions of their family, which, in turn, are viewed within their larger social context (Auerswald, 1987). In-home treatment carries with it empowerment as a tenet. The family is viewed as the pivotal focus of involvement; the helpers are facilitators. In-home treatment is a concrete demonstration of that philosophy.

Advantages of In-Home Treatment

In the family's home, the therapist can get a more accurate, natural sense of how a family functions--a less pathological picture of a family (Braverman, 1974; Sperekas, 1974). Often, coming into an office for 'help', implies that the family is somehow 'sick'. In a family system with a child acting out the family pathology, labelling the family as pathological or

dysfunctional can further entrench the 'illness' of an identified individual. In the home, the whole family can more effectively be involved and scapegoating is more easily cirvumvented. Sperekas (1974) notes that during office visits, "we thought and diagnosed in terms of endogenous, exogenous, neurotic and psychotic depressions. In the homes, we became vividly aware of the environmentally-induced types of depressions which really did not relate to the more traditional ways of viewing depression" (p.174).

When treatment occurs in the home, it is more likely that all members will be together. This makes it easier to explore and see the issues more clearly since all members are together and in their own environment. Sperekas (1974) also reports that the practitioners were able to "judge from firsthand experience the accuracy and perspective of the presenting history and nature of the complaints" (p.173). In an office, there is sometimes uncertainty and uneasiness in determining which part of a history is reality and which is not. The assumption follows that family secrets and hidden problems may emerge more easily when sessions occur in the home. The family is often more cooperative when they see the therapist as caring enough to come to them and risk on the family's terms (Moynihan, 1974). The family sees the home visit as concrete evidence of a willingness to truly offer assistance. In-home treatment offers an opportunity to assess the stresses of a family first-hand; implying a better, quicker family assessment (Horejsi, 1981).

Being in their own setting allows the family members to feel more receptive to treatment, as they are comfortable in their patterns and natural behaviours. They are much more likely to demonstrate their normal interactions. The therapist can see more of the strengths of the family during home sessions. The contextual cues may help trigger maladaptive behaviours that may be more controlled in an office visit where the physical behavioral cues are not the same. The many cues in the home tend to evoke typical behaviour patterns.

One might argue that the interruptions of the family's daily living would prove disruptive. Sperekas (1974) found that those events were opportunities to achieve therapeutic gains. Treatment in the home allows more involvement in the broader family system. Solutions are developed at the time the real issues arise, their effectiveness is maximized by occurring in the home as opposed to artificial opportunities in an office session which may not necessarily generalize to the home. Behaviourists tell us that generalizatility of treatment is most likely when the treatment context is as close as possible to the context in which the problem actually occurs (Patterson and Fleischman; 1979). Thus, generalizability of in-home treatment is not an issue since the context of treatment is most similar (except for the presence of a treatment person or therapist) to the context of when the problem occurs.

Outcome Statistics

Many of the publications regarding in-home treatment consist of single case studies, with no attempt to measure outcomes. Weak methodology and a paucity of controlled studies does not allow for clear guidelines as to the efficacy of such programs or generalizability of the claims made about such programs. Although several programs in the United States have shared their in-home treatment experiences in print, Frankel (1988), in his review of research on home-based services in child protection, reports that there are few detailed descriptions of intervention approaches. He notes that, in spite of the fact that home-based services seem particularly appropriate in cases of child abuse and neglect, programs rarely distinguish between the two areas. Therefore, outcomes are difficult to determine when the descriptions are not clear.

At Wayne State University in Detroit, the PACT (Parents and Children Together) program--established in 1977--has demonstrated a 95% success rate in preventing the removal of children referred to them by child welfare agencies in 1984-85. This is superior to the rate of reuniting children with their families from foster care--35% (Van Meter, 1986). PACT trains graduate students from social service programs and they maintain caseloads of eight families. The counsellors offer two hours per week of direct service (counselling, goal-setting, and contracting) as well as additional support services to each family (advocacy, referral). Parent groups and a twenty-four hour emergency telephone service

are available. Kaplan (1986) reports that "PACT emphasizes goal-setting; behavior management; a strong, trusting counsellor-family relationship; social learning theory; role modeling; education; creating and strengthening supportive systems for families through an ecological approach; and effective coordination of services through family support and advocacy"(p.81).

Homebuilders of Tacoma, Washington, reported that between 1975 and 1984, they served 1,921 families (Kaplan, 1986). Client-reported satisfaction on follow-up, from 1975 to 1977, indicated that 97% reported "continued satisfaction with the crisis resolution" (Kinney, 1977). Twelve month follow-up information, available after September 1982, indicated that 90% of the children targeted for residential care avoided placement. Kaplan (1986) also reports that three-month follow-up of the families discharged showed that 94% of the children remained in their homes. Kaplan (1986) writes that the goals of the program are "to prevent out-of-home placement of family members and to increase family integrity through immediate intervention that defuses the crisis, stabilizes the family, and teaches family members new problem-resolution skills, so that they can avoid future crises" (p.68-69). Therapists (who possess master's degrees) carry caseloads of two families with whom they work over a four to six week period. They are available to families on a twenty-four hour basis and spend, on the average, ten hours per week of face to face contact with each family. They do not

employ support workers. "Primary treatment modalities include client-centered therapy, behavior and emotion management, behavioral rehearsal, communication skills building, rational emotive therapy, crisis intervention and concrete services (such as provision of food or transportation)" (Kaplan, 1986; p.70).

Kaplan (1986) also notes outcome figures of the Children's Services Division (CSD) of Oregon, where, since 1980, out of home placement has been avoided for 70% of the children served by their in-home program. CSD provides three month, time-limited service. Families "receive up to thirty-five hours of direct service, approximately two hours per week, most of which is in-home. Interventions include multiple-impact therapy, structural family therapy, stratecgic therapy, and communications theory. Emphasis is also placed on interfacing and working with community services...The program does not offer twenty-four hour service" (Kaplan, 1986; p.62).

Frankel (1988) states that while "reported rates of placement prevention were impressive" (p.144), there is only one controlled study of an in-home program available: a "family-centered, home-based demonstration project carried out in the Ramsey County, Minnesota, child protection service" (p.147). Seventy-four families were randomly assigned to either traditional child protection units or the experimental group. Three months after termination, 67% of the families in the experimental group and 45% of the control group families were still intact. Children in the experimental group who were

removed from their families spent significantly less time in care.

Cost Effectiveness

Cost effectiveness is touted by proponents of in-home treatment in the apparent belief that if a program can be offered for less money, it is somehow intrinsically better then another program. Authors write that they see such treatment as more cost-effective than present methods of treating the family after a child or children have been removed. Kinney (1970) claimed that the Homebuilders Program cost "$2,331 less per client to provide intensive family crisis services than it would have cost to place these people in foster, group, or institutional care" (p.672). Van Meter (1986) reported that "by figuring the days of foster care avoided, by either nonplacement or early return...the cost of the PACT contract" was estimated to have saved "about one million dollars" (p.83).

Kaplan (1986) reports that Home and Community Treatment in Madison, Wisconsin estimated the annual average cost of service to be "$11,250 per family, compared to an average inpatient annual cost of $86,000 ($236 per day)" (p.68). Maine Home-Based Services compares the total yearly cost of their program--$3,125 to $6,250 per family--to out of home placement in Maine: $4,500 for foster care; between $10,000 and $12,000 for group homes; $15,000 for emergency shelters; $20,000 for state institutions; and from $25,000 to $30,000 for private treatment centres" (p.79).

However, estimates of cost effectiveness are discussed as if every child not treated would have been placed, which would seem to be highly questionable reasoning. The wide variety of services and resources utilized in the absence of in-home treatment would make prediction of cost very difficult. "The most expensive forms of care are often overused in projections of potential placement costs" (Frankel, 1988; p.151). Frankel also points out that if home-based services can be proven "truly effective, they may be worth additional expenditures" (p.153). Cost effectiveness is not the only important criteria upon which to judge whether a home-based program is effective. If such programs are effective in improving family functioning, preventing family fragmentation and helping families to 'graduate' from being child welfare cases; then their (perhaps increased) costs are justified.

Parent Training

Parent training is an important component of any in-home program. The review of parent-training literature provides examples of techniques that could be included in an in-home program and integrated with a systems model. Olds (1980) writes that there "appear to be at least as many factors contributing to maltreatment as there are different forms of abuse and neglect..." (p.174). Dadds (1987) reports indications of a "large environmental component" (p.344) in treating acting-out children. "When programmed change occurs in parents' behaviour, durable change in the child's behaviour has been demonstrated"

(p.344). Writers in the field of family violence have noted that there is a 'multidimensional nature' to violence in the home (Gelles and Maynard, 1987) and that many abusive parents can benefit from more comprehensive forms of skills training to address the fact that the cause is 'multi-determined' (Scott, 1984). Campbell et al. (1983) discuss that "it would be nearly impossible to isolate a primary effective component" (p.154) in cases of child abuse and neglect.

Brunk et al. (1987) reported that abusive parents have been described as rigid and intrusive in their family relations while neglecting parents demonstrate low rates of interaction with their children. From these differences, the authors suggest that "treatment of abusive families should promote increased parental flexibility in responding to child behavior, whereas treatment of neglectful families should develop increased cohesion and greater parental responsivity" (p.172).

Chant and Nelson (1982), note that "parent education is regarded by many family practitioners as an important method of preventing or alleviating interpersonal difficulties between parents and their children" (p.271). They reported that when a parent improved their communication with their child, a "reciprocity effect" (p.272) occured. The child increased their expression of feelings after the parent increased their self-expression.

Child abuse and neglect should not be solely perceived or treated as simply parental discipline deficits or deficiencies in

handling stress. In-home treatment and training are provided in areas such as; "parent-training, stress reduction, self-control, social support, assertiveness and life-skills training, leisure time, health maintenance and nutrition, home safety, job placement, marital counselling, alcoholism referral, money management, and a variety of pre and post-natal prevention services for young, single mothers" (Lutzker and Rice, 1984; p.520). The focus is to help the family build an environment that will reduce the likelihood of further abuse or neglect.

Campbell et al. (1983) propose an "ecobehavioural approach" to prevent child abuse. They suggest a multifaceted intervention program to reduce family stress. They dealt with stress within the parent (manifesting itself in migraine headaches) by teaching relaxation techniques. Parent-training enabled clearer parent-child communication and increased child compliance which further reduced the stress, both within the parent and the family. As well, marital counselling allowed the parents to communicate and deal with marital problems, improved the marital relationship and the children ceased to be scapegoated.

The concept of parent-training has been used to successfully reduce episodes of violence in a child-abusive parent (Nomellini, 1983; Scott,1984). The same researchers have indicated that such applied treatment research with child-abusive families is often difficult, due to the private, low frequency and observationally inaccessible nature of the abusive act. In-home treatment may be one way to circumvent that difficulty in addressing issues that

are easily hidden in group training situations or office sessions.

Bunyan (1987) describes a case study in which an in-home behavioural approach is used to treat a family with a four year old at risk of abuse. Rather than working from a deficit model, the therapists were able to see the strengths of the parents. Parental feelings of inadequacy were addressed by helping them to see their role as the agent of the change. Increased awareness of the importance of their integral role in the positive change in their family helped to focus on what they did well rather than on their failures.

Bunyan (1987) also suggests that, often, the behavioural techniques proposed in a therapeutic program were not new to the family, rather, parents had often attempted to implement similar techniques but their previous application had been inconsistent. From Bunyan's perspective, "parents become the real agents of change. The professionals become the advisors and partners in the therapeutic process; they give back mainline responsibility to the parents, who do the direct work of modifying the child's (and, incidentally, their own) interactional problems" (p.238).

However, Brunk (1987) raises the issue that although parent-training is effective in reducing identified negative behaviours, it is not clear that parent-training automatically increases positive behaviours unless they have been specifically targeted. Unless other dynamics are addressed, only the behavioural goals will change.

FAMILY THERAPY

According to Masten (1979), in her review of outcome research in family therapy as a treatment for children, the past few decades have looked on the family as an interactional system that is central in the maintenance of childhood psychopathology. She also noted that family and behavioural intervention strategies are gaining preference over traditional individual child psychotherapy approaches. However, she found only six studies (out of fourteen that met the basic criteria for the review) with controls. She concluded that the data base was too thin to substantiate the claim that conjoint family therapy is the treatment of choice for children or even any particular subgroup, but neither was there strong evidence to the contrary.

The literature does not demonstrate very clearly how changes are effected in families dealt with by child welfare agencies. Attempting to search the literature is frustrating--one finds almost nothing in the area of family therapy in child welfare. It is not clear whether the information is categorized in some other area or is just not present in the literature. Most of the sources regarding treatment are found in the psychological literature--which tends to a more intrapsychic view of family problems. However, a realization appears to be dawning on researchers, that more systemic changes are required. Brunk (1987) sees maltreatment, within the systems/ecological model, as resulting from the "interaction of multiple factors that are nested within four ecological levels: the background of the

parent, family relations, family transactions with extrafamilial systems, and cultural variables that support maltreatment." (p.171).

Brody and Forehand (1984) report that although behaviours directly targeted for intervention improved following a parent-training program, when the marital subsystem was distressed, "generalized changes (i.e. those not specificaly targeted in the intervention program) [were] less likely to occur" (p.295). Bunyan (1987) writes that "research has demonstrated relationships between personal and marital adjustment of parents and observed child difficulties" (p.239). Dadds (1987) concludes that "the problem for clinicians becomes one of retaining the demonstrated efficacy of producing short-term change in child behaviour by directly modifying parent-child interactions while addressing the contextual aspects of family functioning" (p.354).

A systems approach in treating child welfare families has been glaringly absent in practice. Gelles and Maynard (1987) question the "missing linkages" between family violence and the use of a family systems model. They wonder why a systems practice has apparently not emerged in practice: whether it is due to the fact that the individual psychopathology model has been so prevalent in psychotherapy and in treatment agency philosophies, whether family therapists are so busy treating catastrophes on a daily basis that they are too burned out or too close to the situation to analyze the system issues, or whether

family therapists and those treating child welfare cases are not talking to one another.

Mckinney (1970) reported that although family therapy is seen as an effective approach in the resolution of family problems, little has been said about how it can be adapted for use with 'multideficit' families. How does family therapy help such families to be motivated, open to change and how does it increase their access to opportunities available to family members? Many of these families are in the lower socio-economic stratum. Aponte (1976) writes that the "relationship between mental health and poverty is not so much a matter of the emotional consequences of the lack of capital as it is the social conditions sometimes associated with being poor" (p.432). Rothery and Fusco (1986) note that "economic and social resources or support networks act as a factor that mediates the effects of stress" (p.60). Whether a family is poor or "underorganized" (Aponte, 1976), the lack of available resources increases the likelihood of damage in the face of stress.

Brunk (1987) compared multisystemic therapy and parent training in the treatment of child abuse and neglect and noted that "multisystemic therapy provided certain advantages over group parent-training" (p.177). Multisystemic therapy was more effective at restructuring parent-child relations, maltreating parents showed increased effectiveness in their attempts to control their children's behaviour, maltreated children exhibited less passive noncompliance, and neglecting parents became more

responsive to their children's behaviour. The authors noted that some of the advantages of the multisystemic therapy may have been due to the fact that treatment occurred in the families' homes.

In addressing the issue of family therapy in an in-home, short-term program, the topic of 'brief therapy' must be touched upon. de Shazer (1985) writes that brief therapy is not an inferior form of treatment (as opposed to long-term therapy). Rather, because most clients tend to "stay in therapy from six to ten sessions" (p.4), the therapist must make use of such a realistic time frame instead of idealistically believing that there is an unlimited amount of time in which to work with a client. Brief therapy opposes the long-term therapy intention of personality reorganization or attempts to "correct any causative underlying maladjusments" (de Shazer, 1985; p.6). He outlines clearly defined symptoms, specific behavioural goals with time-limited interventions as the premises of brief therapy.

Langsley and Kaplan (1968) demonstrated that by treating the families of patients identified (by their families) as being in need of psychiatric hospitalization, admission was avoided in 84% of cases treated with outpatient family crisis therapy. Post-treatment follow-up indicated that those patients were less likely to be hospitalized even after treatment ceased. For those that eventually did require hospitalization, the duration of their hospital stay was significantly shorter than for those in the control group.

Brendler (1987) describes an interesting program that

addresses the issues of treating entire families but neatly sidesteps the concept of in-home treatment. At the Philadelphia Child Guidance Clinic, the whole family is hospitalized. Although the outcome statistics are not presented, the program treats an entire family twenty-four hours per day, if necessary, with a multidisciplinary team of therapists. The program clearly utilizes structural family therapy (Minuchin, 1974). They address the issue of the necessity of helping families to organize their outside network in order to facilitate an appropriate support system which is available upon dischare from the program.

Family therapy is part of a multisystemic approach that can be effective in dealing with families serviced by the child welfare system. Rothery and Fusco (1986) write that "reinforcing the authority and nurturing abilities of parents, establishing age-appropriate expectations for children, reinforcing family competence with respect to problem-solving and role performance" (p.64) are structural interventions to improve family functioning.

CHAPTER III

FAMILY SUPPORT

Family therapy alone does not entirely meet the needs of child welfare families. The literature has begun to demonstrate that family therapy can be effective in treating families with children manifesting symptoms of family difficulties. Studies indicate that comprehensive, multidimensional interventions are more effective than a single intervention method (Kaplan, 1986). Brunk (1987) recommends that "intervention may need to focus on any one or combination of systems" (p.173). Braverman (1974) discusses that in-home family therapy offers an intensive period of treatment, but "that psychotherapeutic intensity does not produce quick change" (p.190). She also suggests that extended home sessions may be an option to help people assimilate affective experiences. The concept of in-home family support can be an additional component in providing the intensity required to help a family incorporate the structural changes arising from family therapy sessions into their day-to-day interactions.

If the literature regarding in-home treatment and treatment in child welfare is scarce; there is even less regarding family support. However, the descriptions of in-home treatment or family systems therapy with abusive or neglectful families do include family support tasks--although they do not differentiate the roles. Brunk (1987) reports that "approximately 88% of the families also received informal parent education regarding more

effective child management strategies and more appropriate expectations for child behavior" (p.173). In Bunyan's (1987) article, the entire treatment approach (a behavioural one) could be termed a family support function.

Campbell et al. (1983) describe a parent-training component in their 'ecobehavioural approach' to prevent child abuse. Again, this falls under a family support mandate. Project 12-Ways in Indiana offers "parent-child training", "social support", "basic skills", "leisure time", "health maintenance and nutrition", "home safety, alcoholism referral", "money management, and a variety of pre- and postnatal prevention services for young and unwed mothers" (p.520) in addition to "treatment". All of which fit into the description of a family support role.

The term, 'family support' has been used in the literature, and in practice, to refer to a number of different concepts that would best be served by separating them. The most obvious distinction, according to Whittaker (1986), is that between formal (professional helpers) and informal social support systems (resources that exist in the world of a given family). Informal networks may include family, friends, church, neighbourhood, voluntary associations, etc. Rothery and Cameron (1985) discuss several types of social support: concrete support (material aid), educational support (knowledge and skills), social integration support (accessing available networks), emotional support and environmental action support (advocating to reduce

external pressures on a family or increase availability to social resources).

The topic of social support is an area in which research is burgeoning (Whittaker and Garbarino, 1983; Gladow, 1986; Trute and Hauch, 1987). The evidence indicates that informal social support networks serve as a buffer to stress and an aid in coping with life transitions (Whittaker, 1986). Cameron (1983), makes the distinction between those systems that are informal (friends and family), community supports (schools, health care agencies) and helpers (friendly visitors, social welfare agencies). Whittaker (1983) writes that "'success', however defined, at the point of discharge or termination of services is not necessarily a good predictor of the child's ultimate adjustment to the community. A more powerful predictor appears to be the presence or absence of a social support network which can continue, enhance, and build on gains made during the course of formal services"(p.174). Thus, professional supports cannot replace, indeed, they must work with (or help to generate) informal, natural support networks.

Professional child welfare systems advocate and practice the concept of 'family support workers' to both facilitate the growth and development of children and offer support to families who are identified as having difficulties managing their children. The roles of these workers range from friendly visitors, providers of recreation services, homemakers, drivers, problem solvers and guards preventing escalation of violence--in practice, they are

expected to perform any service desired. Just as Gelles and Maynard (1987) describe an apparent gap between research and the rationale of practice in treating family violence, in this instance, there exists a chasm between theory (such as it is!) and practice in family support programs. There seem to be no assessments of existing programs in the literature nor does it appear that there is any informal sharing of experiences (Rothery and Cameron, 1985).

A family support program must be able to provide a range of different services that can be tailored to the particular needs of individual families. Whittaker and Garbarino (1983) describe these as "packages of services". This carries with it the implication that workers must be able to call on a variety of skills and knowledge rather than specialized expertise. The accessing and coordination of resources from other sources is also a necessary component of such a program.

Rothery and Cameron (1985), in their study of family support practices, interviewed 203 child protection workers regarding 547 cases in 16 child welfare agencies across Ontario. They found that, "programs with high 'support' dimensions (i.e. high level of direct contact, broad variety of helpers, broad variety of help) were the only programs with an identifiable superior impact on child placement and case closure indicators..." (p.79). Frankel (1988) reported that one study (in which clients, workers and referring professionals were asked to rate an Iowa program) found "design characteristics (service in the home, flexible

hours, practical help) more helpful than technique characteristics (teaching communication skills, help with expressing feelings, help with understanding behavior)" (p.150). Olds (1980) notes that the "key feature of any attempt to improve the delivery of preventive services would be a strong outreach component, including frequent home visits." (p.177). He also points out that the timing of an intervention is important, in that the earlier the work is begun with parents, the more its effectiveness increases.

According to crisis theory (Golan, 1978) when workers intervene quickly and intensively, the effectiveness of intervention is higher. Small caseloads and early reaction to immediate needs also contribute to increased effectiveness (Yamamoto, 1967; Gwyn and Kilpatrick, 1981). Families in crisis react positively to the alleviation of their stress and are most open to such help due to their limited coping repertoire at the time of crisis (Langsley, 1968).

Intervention in a family should be very structured, clear, goal-oriented and time-limited (Whittaker and Garbarino 1983). Rothery and Cameron (1985) discuss indications in the literature that for a family support program to be successful, the aims must be clearly stated. It is important to differentiate between the range of appropriate family support programming for different client groupings such as "single parents, young mothers, adolescents, multi-problem poor families, native populations and other ethnic subpopulations". In any family therapy, support, or

intervention model, the individual needs of a given family must be addressed.

Intervention Workers

The distinction between 'change' and 'support' programs is necessary to this discussion (Rothery and Cameron, 1985). Neither is better or worse, but the delineation is important in order to distinguish between the differing foci of the two approaches. 'Support' strategies stress a focus on social problems and the connection of the family to community resources as opposed to the counselling, skill-teaching and general improvement in individual and family functioning of 'change' strategies.

It is clear from the literature that the role of family support workers is not clear. The literature discusses the issues of programs, administration, or assessment and goal-setting in very general terms. There are no descriptions of the philosophical orientation or practical applications of such a role. Witness the confusion in training family support workers--people with a variety of training ranging from no post-secondary education to graduate degrees in unrelated areas. Few colleges in Canada offer programs in 'Family Support'--such workers graduate from 'Child Care' or 'Social Service' diploma programs. Grant MacEwan College in Edmonton, instituted one course (Family Support) in the 'Child Care' program, in 1987. The confusion in roles was evident in that they were teaching family therapy, using David Freeman's Techniques of Family Therapy as the text.

The role of the family support worker is not to perform therapy, but to support the therapeutic goals in the home. There appears not to be a clear 'Family Support' curriculum--perhaps because the role is unclear?

Family support workers are usually trained in the field of child care, so they rarely come to a family support program with a systemic view of the family. They are taught to assess the needs of an individual child, take control, intervene accordingly and advocate for the child. That basic theoretical perspective, more often than not, makes it difficult for them to take into consideration a systemic and/or ecological perspective.

From this point, I have chosen to use the term 'family intervention' (referring to the role of a professional in-home 'helper') instead of 'family support' to emphasize the contrast between the two tasks. A 'support' worker provides a nurturing, supportive, friendly function. An 'intervention' worker acts as the facilitator/encourager of change within the family.

The difficulty of shifting perspectives and ways of thinking cannot be overstated. To go from having the responsibility in a very specifically outlined, controlling, structured way of approaching and resolving issues to being less directive and facilitating the actions of others is not an easy task. For example, consider the following situation:

> A 21-year old mother of three (aged 2 years, 3 years and 7 months) has recently moved to the city from an isolated reserve town in B.C. She was living in an abusive relationship with a man from the reserve who is the father of the three children. She underwent severe physical abuse and death

threats until he began to hit the children and she left him. The presenting problem is that the 3 year old is out of her control, is violent and abusive towards her. At the first home visit, the child is walking around the house with a doughnut. The mother says, half-heartedly to him two or three times, " I told you that you couldn't have a doughnut. You're supposed to eat at the table and, anyway, you should be having a sleep."

The conventionally trained child care worker would move in and 'model' the right behaviour. They would give a clear directive to the child, possibly to finish the doughnut at the kitchen table and then a nap would follow. If the child did not comply, the worker would then begin to set limits, perhaps giving the child another warning, with the consequence of non-compliance also clearly stated; "Please, go to the table to finish the doughnut. If you don't, I will take it from you and you will go right to bed." And the drama would unfold...

The family intervention worker asks the mother what she wishes to do about her child's lack of compliance. After much confusion, as parents in this situation are not used to being asked about how <u>they</u> want to handle the situation, she may (as she did in reality) answer, "I want him to sit at the table to eat his doughnut". The worker would support the mother in her process of taking control, being clear about her expectations and ensuring compliance from her child. In this situation, the worker asked the mother, "How many times have you asked him to sit at the table? How many more times do you want to ask him before he is consequenced?" The worker focuses almost exclusively upon the mother, helping her to act on <u>her</u> decisions. The worker would not allow the mother to give up or back down,

instead, through similar feedback questionning, the mother is given the message that she does have the competence and skill to manage her child. As Bunyan (1987) notes, such treatment does not provide wholly novel techniques to parents, but allows selection of the most appropriate procedures and helps parents to consistently apply them.

In the example above, with the support of the intervention worker, the mother carried the screaming child to his bedroom. He had been given a reasonable number of choices, with the consequences made very clear to him. Initially, she twice carried him back to his room when he came back out. Finally, she decided to hold the door shut until he settled. He screamed and swore for 20 minutes. With the worker's help, she calmly repeated her expectations that he settle in bed quietly and then the door would be opened, which it was. The child was still sleeping when the worker left. When the worker returned the next day, the mother reported that the child woke up, hugged his mother and told her that he loved her.

Many child care workers find the perceptual shift from being child-focused to family-centredthis a very difficult one. Again, of the two types of tasks, one is not intrinsically better than the other, but the worker must address different goals in different situations. Two variables must be identified; the parent's ability to parent, and the behaviour of the child. The family support worker, trained in the child care philosophy, generally works in an institutional (or the like) setting, in a

parenting role. The support worker's role is to focus on the child (and the child's behaviour). It is a very directive, hands-on, teaching function. The job is to take control and provide predictable structure in order to provide nurturing and stability for the child--a pseudo-parent, if you will. Advocacy for the child is an important component of such a role. The family support worker can, often, find themselves in an almost adversarial position with the parents in advocating for the child.

The intervention worker must shift from the child-centred focus of the support worker to a focus on the family system. It is not only a different way of thinking but a shift of goal. The intervention worker works within the family--in their home. Empowering the parent to parent more effectively is the main task. Their role is that of facilitation--helping the family members to continue the goals established in family therapy; to objectively examine their behaviour, practice alternatives and to help them to make connections between their behaviour and its consequent impact on others.

The area of training of intervention (or support) workers is nonexistent in the literature. One can barely find program descriptions, let alone issues for the training of such in-home workers. The initial step in training the family intervention worker is to teach them <u>not</u> to be active in doing <u>for</u> the family. This is the most important step as it may contradict everything they have learned. Most family support workers take children out

to movies and other outings, drive family members to appointments or shopping and basically end up being the chauffeur and 'go-fer'. They do not feel that they are accomplishing anything unless they are doing something. Families who have a history of dealing with outside agencies are often very skilled at allowing the family support worker to feel useful!

The family intervention worker must understand that whenever they are 'doing' they are probably doing something that the parent could do. Often, they are not even aware that they are doing until it is pointed out to them. Techniques, such as occasionally taking along another worker, writing clear visit reports and especially video-taping sessions prove valuable for feedback, supervision and training. Such procedures help to keep the intervention worker very goal-focused.

Family intervention workers must be trained in problem identification and clarification. Although the social worker provides the clear, goal-focused assessment, it is still necessary for the intervention worker to ensure that they are not losing track of the issue upon which to focus. Questions such as "why?" are not helpful--action on the family's part serves them much better. Strategic family therapists believe that whatever a family does (no matter how dysfunctional it appears to outsiders) has some functional aspect, even though the function may have outlived its purpose and become a problem itself (Nichols, 1984).

It is much more helpful to ask "what?". What is happening for the other members when the problem occurs? What happens

before, during and after the problem occurs? Systemically, focusing just on the 'identified problem' is not helpful. It is important to help the fmaily make the connection between what they do and what their child does. Helping the family to understand the antecedent and consequent events of the behaviour in question helps them to better understand the issues (Herbert, 1979). It is a move towards 'it's something in you' to an interactional perspective of 'it's something in the relationship'.

The course of the intervention must travel the fine line between addressing the presenting problem while not overly focusing on the individual who is identified by the family as being 'the problem'. Focusing on the 'identified problem', would be accepting the framework of the family that there is one 'bad' member against the 'good guys'. Constant reframing from the individual perspective to the systemic is important. It can be as simple as refusing to accept the view that the child, "...never listens, won't do what he is asked..." and saying to the parents, "You are not being clear about your expectations or are not insisting that the child listen to you...".

The intervention worker begins laying the foundation from the very first interview of how to address and resolve problems. Rather than moving in with advice and immediate action, questions that challange the family to generate their own ideas is more therapeutic. The family has strengths and competence--the family intervention worker recognizes them and provides a safe

opportunity within which the family can practice alternatives.

Much of the intervention worker's task is that of normalization for the family. Many families who come to the attention of child welfare authorities have very few successful experiences with parenting, often having no positive role model from their parents. Some of their expectations (both of their children and of themselves) may be unreasonable. Some parents don't think that they should ever be angry or upset with their children and are unsure of age-appropriate discipline to use. Other parents may expect a child to understand concepts and have insight far beyond their developmental abilities. Some parents have personal issues that preclude them from being able to meet their children's emotional needs.

In short, family intervention, as described above has a strong behavioural and teaching component--helping the parent to understand issues such as positive, negative and differential reinforcement; teaching; shaping; modelling; cueing and prompting; etc. (Herbert, 1979; Dreikurs, 1964). Appropriate child management techniques from 'time-out' to various methods of consequencing noncompliant behaviour (Wolfe, 1981) are in the repertoire of the intervention worker. The intervention worker can make suggestions to the parent, but only after the parent has exhausted their own repertoire. The parent must feel comfortable with trying, and possibly failing with, a new technique. Even a failure, however, would provide valuable learning as the worker and the parents analyze what happened. The behavioural thrust is

complementary to the major changes that are occuring in family therapy. The family therapy addresses the structural changes in the family system, while the intervention worker addresses instrumental changes in the family's day to day living.

It is notable that the training format for helping child care workers or family support workers to shift to thinking as an intervention worker is parallel to the method of intervening in a family. Many of the principles of adult learning clearly fit for both instances. Brundage (1980) points out that, "Role learning is carried out not through formal, logical, or sequential processes but through interpersonal interactions, modelling, and experimenting. The role of learner, therefore, can be learned most productively when the adult can observe and interact with other adults...and when he has a safe environment in which to test out similar behaviour." Quoting Lewin's theory of change, Brundage points out that one must have an "...awareness of a need to change, or 'unfreezing'...dealing with the need to change in positive ways...and consolidation and integration of the changes into other aspects of life, or 'refreezing'..."

Family Therapy vs Family Intervention Role

It may appear, from the discussion of the role of the family intervention worker, that the line is blurred between what constitutes the role of the intervention worker versus that of the family therapist. In the ideal situation, the role is one and the same. The family therapist has the skills to perform the

intervention function, but given the time and salary issues, it is often necessary to delegate the more time-consuming role of the family intervention work. Kaplan (1986), Bryce and Lloyd (1981) and Maybanks and Bryce (1979) have noted that in-home intervention is performed by volunteers with no formal training to Ph.D.'s in psychology or counselling.

The role of the family therapist is that of a director. With a systemic perspective, they are responsible and accountable for directing the treatment process. They set the goals with the family and the intervention worker. The interactional patterns of the family are identified in the family therapy sessions and the goals to be worked on at home are identified. The family therapist is also responsible for supervising the intervention to ensure that it stays on track.

The intervention worker provides input into the initial goal-setting. As a result of their longer hours of work in the family, they have more information in the constant monitoring of the process of goal-attainment. They may provide information that results in complete changes of the goals or, merely, their fine tuning. The intervention worker uses any family interaction as an opportunity to emphasize the desired family changes.

This is very intensive work with very powerful family systems, on their 'turf'. As previously noted, DeMaria (1986) pointed out that, very often, many other agencies/professionals have failed these families and they may be more difficult to engage. Kuypers and Trute (1980) write that the most important

precondition for effective family practice is the *avoidance* (italics mine) of process traps; for example, being unable, while working in crisis, "to translate mentally constructed interventions into action" (p.63) because the worker has never done it before. In striving for predictable comfort, the worker will choose low risk, conservative actions. For the intervention worker, they are all but impossible to avoid, so the important task becomes how quickly one recognizes and extricates oneself from such traps. Family intervention workers are working <u>inside of</u> rather than objectively viewing the family crisis. Intensive goal-setting, supervision and an ability to learn from (reframe) 'mistakes' that one must, inevitably, make in order to learn; can help prevent the worker from being 'sucked into the system' during the periods of time they spend as part of the family.

Gottlieb (1983) writes that social support networks are as important for workers as they are for clients. The importance of formalized group/peer supervision for both the family therapist and the family intervention worker cannot be overstated. Such support can balance the perspective of the worker or therapist, who, often, feels overwelmed in becoming part of the family dynamics. This topic will be further discussed in the section on supervision of intervention workers.

CHAPTER IV

THE PRACTICUM

An In-Home Family Intervention Program

This chapter consists of a description of the program, the families who participated and the work we did together. We tried to offer as collaborative an environment as we could, with the families being a part of every step of the process.

Clients and Referral Process

The program was offered through Child and Family Services of Winnipeg South for a three month period from the beginning of May to the end of July, 1988. CFS South is one of several private agencies which provides child welfare services to families in the city of Winnipeg. Funding for these agencies comes primarily from the provincial government. Service was provided in the families' homes--up to two hours of family therapy in addition to up to ten hours per week of time spent with the family intervention worker.

Families were referred by the Child and Family Service social workers from late April to early May, 1988. The social workers filled out a referral form (Appendix A). The families (either self-referred or identified by the community) had been assessed by Child and Family Services as having difficulties in managing their children. The families were referred to the program because of the risk of placement of their children in foster or group homes as a result of the family difficulties. Child and Family Services maintained primary responsibility for case management. It was hoped that the families would not be

involved with other therapists, although two of them did maintain contact with psychiatrists during the duration of the program. During treatment, attempts were made (some successful, some not) to incorportate any other helpers/agencies involved with the families. This issue will be discussed further in the discussion of specific families.

The treatment process was an intense, time-consuming one, and included the ongoing supervision of the intervention workers. It was decided that the program could serve seven families. Experience caused me to expect that approximately one-quarter of the families would not complete the program, so 11 referrals were accepted. However, one family was rejected due to severe psychiatric issues which would have required longer term treatment; four of the families cancelled the initial meeting; one declined to participate after the initial meeting; one cancelled after the second assessment meeting. A total of six in-home assessments were performed and we went ahead with five families.

Interviewing Process and Selection Procedures

The first post-referral meeting was arranged by the CFS social worker at the family's home. At that meeting, attended by the parents, the CFS social worker and myself, I explained the nature of the program, treatment issues and time expectations of the process. The families were then given two days to decide if, after they fully understood the nature of the program, they still wanted to go ahead. The next meeting was then scheduled after

they had called me back with their assent. The CFS workers were invited to attend all subsequent sessions, but due to their busy schedules, they did not attend again until the discharge conference. The families were aware that the CFS worker was regularly updated on the progress of treatment. This seemed to work well. The CFS workers did not see themselves as being therapists, they were case managers. Separating the functions of the child welfare mandate and the therapy function was the most effective design. The CFS workers were seen as the ones with the power to take away the children. The families appeared more relaxed without the presence of that authority figure. The families were not very close to their workers and it might have been difficult to include yet another person (as well as the therapist and the family intervention worker) in the therapy sessions. The second meeting included the rest of the family.

At the first treatment meeting a consent to videotape (Appendix B), and two paper and pencil tests were administered; the FAM III General Scale (Skinner, Steinhauer and Santa-Barbara, 1983; Appendix C), and a Problem Checklist (Appendix D). These measures will be discussed in depth in the evaluation chapter. This collection of data, as well as a Child Direct Observation Form (Magura, Silverman and Moses; 1986; Appendix E) which was completed by the Family Intervention Worker during their first meeting with the family; constituted measures used to establish a baseline level on family and child functioning. The three measures were administered again, at the termination session.

The measurements were intended to determine if the treatment would have an effect on self-perceived family functioning, on the problems as each member saw them and on the observed behaviour of the children. The family intervention worker completed a Home Visit Report (Appendix F) after each visit.

The first meeting was utilized to orient the family to the philosophy of the program and allow them to discuss concerns that they had. The family was informed of the positive orientation of the program, the emphasis on strengths--which they all had but of which they were, generally, not aware.

Treatment Process

Conceptual model

Given the often long-term, possibly intergenerational nature of the problems that bring families to the attention of child welfare agencies, intensive intervention was seen as important to prevent family disintegration. Many of these families requested (or social workers insisted on) the removal of the child/children. One hour per week of family therapy, in itself, could not begin to address the issues that required resolution to prevent family fracture. The use of family intervention workers (as opposed to family 'support', which has been previously discussed) was used to augment the family therapy process.

The goals generated during the family therapy sessions became the working goals of the family intervention worker. These goals were constructed in very specific, behavioural terms for the family intervention work. A maximum of three goals

ensured that they would be addressed and not lost in a myriad of tasks. Conceptually, then, the family intervention task was only one component of the role of the family therapist. The family therapist delegated the intervention function due to time and monetary constraints.

The concepts of structural family therapy were utilized in the treatment of the families. Work consisted of helping the family restore and develop a family structure consisting of a clear hierarchy and clear, permeable boundaries (Minuchin, 1974). Some of the assumptions identified by Brendler (1987) were used:

1. The symptomatic child is seen as evidence of problems in the functioning of the larger system--the family.

2. The symptoms are reinforced and maintained by the family's patterns of interaction and by the professionals who are part of the therapeutic system.

3. The child's behaviour, and the family members' perception of it, changes as the family's interactional patterns and structure change.

4. The family is only using a limited repertoire of its available resources and has the potential to develop alternative ways of interacting.

5. The intervention is very present-focused, with the changes occurring in the here and now; those interactional pattern changes will impact on the symptomatic child as well as the rest of the family.

According to family crisis literature, family coping skills

are a major element in the resolution of family difficulty. There is evidence to indicate the quality of the marital dyad/parental unit as being one of the most important resources available to the family. Depending on the healthy functioning of that unit, the family can demonstrate various degrees of coping.

During the initial two to three meetings, the family was encouraged to articulate the goals they wished to achieve during the course of the program. They usually spoke of wishing to "cooperate/get along better", "stop fighting", "be happier". The first sessions were geared towards helping the family operationalize these generally stated goals.

Presenting Family Issues

Physical characteristics

All five of the families were parented by single mothers. One of the mothers was living with a man and another had a non-live-in boyfriend whom she was planning to marry next year. The women were aged 28 to 45, their children ranged in age from 16 months to 17 years.

Three of the women had suffered abusive relationships with their spouses and, for two of the women, relationships with those spouses were antagonistic. These men did see their children, although irregularly The husband of the other woman had died three years previously. The fact that all families were parented by single mothers negated the opportunity to work with the marital dyad. We focused, instead, on ensuring that the women did have support systems.

Two of the women had children fathered by different men and they had never been married. One woman had three children by three different men, the other had two. None of the men were involved with their children.

Three of the women received welfare, one worked out of the home and the other found a job after being on unemployment insurance for a year and a half.

Presenting issues

The families had very complicated intergenerational dynamics. Only one of the families received support from relatives, the rest had family histories of dysfunction and could not look to their extended family for help with problems. There was a common thread of emotional and physical cut-offs with some or all family members for each of the families. One of the women had left her family at the age of fourteen, had lived in foster homes and 'reform school' and had not spoken to her mother since her father's funeral three years previously. Another woman had moved here from another province to escape from her chaotic, intrusive family. Another woman's father was an alcoholic.

In all cases, the behaviour of the children was identified as the major issue, initially. The children were described as, "not listening", lying, "not doing chores", aggressive, refusing to follow house rules, truant, and experiencing behaviour and academic problems at school. It became evident that the children's behaviour was indicative of other family issues.

Lack of money was an issue for four of the families. They

could not afford to spend much money on their children, which the children had difficulty understanding. The women could not afford to go out themselves. Four of the families had no transportation, one did not have a telephone. They could not participate in support groups or extracurricular activities for the children because they did not have the money or the means to get there. Two of the families lived in low rent housing, another was awaiting her divorce settlement in order to find out if she and her two children could continue to live in their duplex, which her husband wanted to sell.

Three of the women, who were single, talked about their loneliness without a partner. Two of them, continually, involved themselves in relationships that repeated patterns of abuse, alcoholism and abandonment. One woman talked about her feeling "like a slut" because she had never been married but had slept with "more than five men". They had no opportunity nor the resources to go out to meet potential partners. They were exhausted by the effort of single parenting with little support, and felt overwhelmed and lacked energy for any activities beyond those required to fulfill their role as parent.

Although, in single parent families more sharing of decision-making between the parent and children appears more appropriate (Morawetz and Walker, 1984), in all the families the intergenerational hierarchy was blurred. Many of the children were elevated to the role of pseudo-spouse and caretaker of their mother. When asked what changes he would make in his family if

he had a magic wand, one eight year old replied, "find a husband for my mom". This boy and his seven year old brother were charged with most of the responsibility for minding their 18 month old sister. One mother, who had a very antagonstic relationship with her 16 year old, found herself unconsciously encouraging her older daughter to enforce discipline on the 10 year old.

These women felt like failures as parents because they felt that their children defeated them by their defiance. The mothers also felt that their children demanded too much attention and time of them. They felt failure that they were not able to maintain the stereotypical nuclear family. They identified that it was their fault that they either never married ("couldn't keep a man") or couldn't prevent the separation. They experienced much conflict in their relationships with the non-custodial parent. Two of the women indicated that their child reminded them of the hated parent. The children and the mothers described feeling "caught" between (triangulated with) the other relationship--the children between their estranged parents, the mothers between their children and estranged spouse. In all the families, the children had assumed their mother's animosity towards their fathers, but one 17 year old girl cried when talking about how much it hurt to only ever hear negative things about her father. The children did not know how to express a desire for a relationship with their father without hurting their mother.

Intervention Techniques

The initial and all subsequent family therapy sessions occurred in the family's home. It was easier for the families--who lacked transportation--to attend and for all members to be present. The family intervention worker was present at all sessions. In one family's case, the 14 year old boy proved too distracted at home, so, after four in-home sessions, subsequent sessions were in-office.

Genograms (Wachtel, 1982; McGoldrick and Gerson, 1985) proved a very effective method of gaining valuable information with all the families and of therapeutically impacting on the family members. All members enjoyed the exercise of talking about family history. They found new family information fascinating. Family secrets became quickly evident; one woman had a child she had given up for adoption, one woman described a pattern of sexual abuse by her grandfather and father and how she had protected her daughter who had no idea of that family secret, one woman's family pattern of family isolation was very evident when the emotional cut-offs were added in to the genogram. The genogram was displayed at all sessions and new information was added to it, it was often referred to and new patterns were identified as the time was right. All of the families found the experience of recording their families a very powerful one.

Asking the family members to perform certain homework tasks was an important component of treatment (L'Abate, Ganahl

and Hansen; 1986). The goals of the family intervention worker were often to help the family complete homework tasks. The homework was generally structurally constructed to strengthen subsystems and help delineate clear boundaries (particularly intergenerational ones). One mother described that she couldn't trust her children to accept her vulnerability because she constantly remembered how her older son would use the information against her. She felt that because he had done it in the past (along with numerous others) so would her youngest two. The mother was asked to keep handy a paper with "The Past" written on it. Whenever the past was interfered in a present interaction, her children and her boyfriend asked her to bring out the paper. The family acknowledged that their mother was no longer functioning in the present, nor was she responding to them. The family intervention worker helped the family to identify when the mother was reacting from her past, until all members became quite good at the game--and had some fun with it as well. One couple was given a date as their homework.

The families worked with during this practicum were fairly disorganized with few family rituals (Wolin and Bennett, 1984). The communication and stabilizing effects of rituals were seen as particularly important. In all cases, the families were encouraged to generate a 'good-bye' ritual at the end of their involvement with the program. The history of good-byes for these families were usually premature and often conflictual. One husband and father, estranged from the family at the time of his

death three years previously, had been charged with assault by mother and daughter one week prior to his death. All of the families had husbands/fathers who had abandoned them, two by death, three women had several partners who they saw as having left them. The ritual of ending gave the family members a model of how endings could be predictable and positive.

Family intervention work constitued a major intervention method. General goals from the family therapy session were operationalized and given to the family intervention worker, who would use them in working with the family. One mother relied on others (from men to her older daughter) to 'rescue' her. She saw herself as a powerless victim. She was helped to manage her 10 year old more effectively--the family intervention worker had to continually point out to her how the 10 year old would divert her attention, throw a tantrum, whine and she would give in. As the woman became more effective in parenting the younger daughter, her self-esteem rose and eventually she told the older daughter that she did not need her to be the enforcer. The family intervention worker used every available opportunity to encourage the mother to follow through on the management of her child. The mother became more self-confident in other areas of her life, she began to examine her victimization in her relationships with men.

The three family support workers met with me once per week for supervision purposes, both individually and as a group. During the individual sessions, we discussed that week's family therapy session and the goals generated for the family. It was a

very specific and goal focused supervision. Discussion centred around their successes and the issues that prevented them or the family from achieving the goals ('process traps). Many personal issues surfaced during these sessions as the intervention workers talked about where they became 'stuck'.

The intervention workers found the group sessions helpful. They were able to talk about their frustrations and their successes. At each meeting, we chose a particularly difficult issue or point of 'stuckness' to discuss. We all found the shared expertise helpful in resolving the difficulty. All of the workers were very knowledgeable regarding community resources and were able to make new suggestions to the group for alternative courses of action.

THE FAMILIES

The R. Family: "The metaphor of the messy house"

Barb, aged 29, a single mother of 3 children, was referred by her social worker because of physical abuse of the older two boys. The school was also very concerned about the home situation. they felt that the boys were physically and emotionally neglected. Her oldest son, David, was aged 8; the middle boy, Matthew, was aged 7 and Sandra, was 16 months old. Each child was fathered by a different man, none of whom were involved with their children. Barb had recently cut off contact with Julio, the father of Sandra. She had hoped that he would marry her when she became pregnant but he began living with another woman, instead.

Assessment:

Barb presented as a depressed, withdrawn woman with flat affect. She was intelligent and articulate. The majority of her interactions with her environment were unrewarding and stressful. Although able to allow relationships to begin to develop she would soon arbitrarily cut them off with accompanying ill feelings. Her father had been dead for three years and she had not spoken to her mother or sister (who lived in Ontario) since the funeral. She had been placed in care since the age of fourteen after having been physically and emotionally abused at home. She expressed anger towards her mother for not protecting her from her alcoholic, abusive father.

She had, initially, trusted and liked the CFS worker, but,

now would not allow much information sharing with her. The CFS worker refused to enter Barb's house because it was unkempt and filthy. They were involved in a power struggle, with the worker insisting that the house be cleaned and Barb resisting. Barb was also involved in a conflictual, pseudo-cut-off relationship with her last boyfriend, father of her youngest child.

Barb was on welfare, had very little money, no telephone and no transportation. She lived in low-rent housing and was socially isolated. She was being ostracized from her Lutheran church for having three children out of wedlock and for her unclean house. She had done some volunteer work with the El Salvadorean community and the last two men in her life had been El Salvadorean. When they abandoned her, she also lost her social circle as she was no longer welcome in that community.

Completion of a genogram highlighted the extent of neglect and abuse experienced by Barb in childhood. She had been physically abused by her alcoholic father and by her mother. She lived in foster homes and 'reform school' from the age of thirteen. Her genogram showed a pattern of isolation, both in her personal relationships and in her relationships with professionals. Barb's home was incredibly messy and dirty. Papers, clean and dirty clothing, toys and books were heaped on the floor and piled against the walls. Sometimes there were cleared spaces in the centre of the living room, at other times, not. She received much pressure from her friends, from CFS, and from the school counsellor (who had visited Barb's) to

clean up. The CFS worker--who had personal issues with cleanliness--refused to come into her house. She would stand on the step to talk to Barb. CFS had provided her with homemakers to clean up the house, but to no avail. Barb was winning the power struggle with outsiders to change her behaviour. It became evident that the housekeeping was a metaphor for Barb's defensive, self-protective way of dealing with the world. Her messy house served to keep unwanted people away. It also allowed her to be a more "relaxed" mother. With her chaotic house, she didn't have to nag at the children to "not touch things" or to "put that away".

Barb was artificially separated from her family--by removal at an early age to foster care and by the death of her father--rather than being allowed to differentiate in a developmentally normal manner. She had never been on good terms with her family even prior to her father's death. She felt abandoned by her mother and father and repeated that pattern of being abandoned in her subsequent relationships. Her children were the source of nurturance that she lacked in any of her other relationships. Barb relied on the oldest boy, particularly at this point, to take care of her. He looked after the younger two, and was very sensitive to her emotional condition and tried to comfort her when he sensed that she might be upset.

Contracting:

We signed a contract for 10 sessions, initially, for the whole family to be present at all sessions.

The following goals were identified:

1) Barb wanted to have her children go to bed when she asked and not remain up until up to an hour later.

2) She wanted to learn how to be more involved with her children

3) Barb identified feeling socially isolated and wanted help in accessing support systems.

Treatment:

Family Therapy:

The first two sessions consisted of assessment and gathering information for the family genogram. At the second session, when asked what changes they would make in their family with a magic wand, the oldest boy answered, "a nice boyfriend for my mom"; the younger boy wished for, "a cleaner house". Barb identified her feelings that if she were a better woman (kept a cleaner house) then the men would not abandon her. Barb was asked not to clean her house. She was told that there was a reason that she needed to keep her house the way that it was and that she was not to take away that protection.

At the third session we looked at the genogram. Barb experienced a great deal of sadness as she saw the emotional cut-offs with her family and relationships. She said, "No wonder I feel so lonely, when I see all the barriers". The boys were very interested in the information that Barb shared for the map. David interrupted often, correcting information. He and Matthew would argue about who was right. Barb was encouraged to begin

defining the intergenerational boundary by telling them not to interrupt or correct her.

During the fourth session, Barb referred to the genogram and was able to talk about her family and how her mother had never protected her from the abuse of her father. She did not want to re-establish contact at this time with her mother. Barb indicated her need for substantial support and how she searched from professional to professional and was never satisfied. She was helped to make the connection between her family's lack of support and her desperate need for 'help' in the present. She was asked to define what she wanted from our sessions. She continued to talk about "becoming a better woman" and "having a cleaner house" so she could "keep a man". It was decided that some of Barb's issues were of an individual nature and it was decided to begin individual sessions in addition to the family sessions.

The next session took the form of a meeting at the school with the school social worker, the CFS worker, the intervention worker and myself. Barb was seen as being very resistant to any contact made by the school. The main aim of this meeting was to dispel that impression. Barb was nervous and somewhat cold towards the CFS worker but the meeting was a good start in improving relations with the school. She agreed to meet again in one month and agreed to a psychological assessment of David. David was difficult to deal with in the classroom, he would sit for hours not doing any work and the teacher felt defeated by

him.

Up until the fifth family session, Barb had been claiming that she really wanted her house to be cleaned, that she and the boys spent time cleaning (although visual evidence indicated no change). During this session, she began to piece together her pattern of cutting-off relationships and her unusually unclean house. She talked about how the house kept unwanted people away (it worked very effectively with the CFS worker), how she wanted people to love her for herself and not for the condition of her house. She continued to receive the message that she needed to have the house in it's present condition, and not to do anything about it.

During the sixth session, Barb responded to the ongoing challenge to her flat affect and intellectualizing. She was confronted about her avoidance of feelings and her ability to talk around and about them, but not to feel them. Barb's defensive and emotional shut-down reaction proved a powerful enactment of her reactions to emotionally charged issues.

During the seventh family session, the family intervention worker expressed some frustration that the goals were not being worked on by Barb. Barb trusted and liked the intervention worker, saw her almost as a surrogate mother. She was very upset and cried when we discussed the fact that there seemed to be other issues to focus on, and that the bed-time routine was only a symptom of some deeper issue. As Barb cried, David watched her quietly for some time, with his thumb in his mouth. Then, he

climbed into her lap and put his arm around her shoulder. As Barb continued to cry, David drew her head to his shoulder and stroked her hair. It was a very powerful enactment of how her needs were met by her children, particularly David. She was able to see that her ineffective request for the children to go to bed was not a sincere attempt at discipline. She hadn't wanted to deal with managing her children, she wanted them to go to bed on their own--to essentially manage themselves and leave her alone. She didn't have the energy to give to them. That was how she felt cared for--when they looked after themselves and nurtured her. Barb was given the homework task of spending 1/2 an hour per week, individually, with her boys. The little girl took up much family time and attention and the boys were generally caretakers. David, because he was identified as a difficult child, took further time away from Matthew, who tended to get lost in the shuffle.

The next session was our first individual, in-office session at Barb's request. She felt that she had issues not appropriate to discuss in front of her children. Barb expressed anger and shut down her emotions. She said that perhaps she shouldn't change. We discussed what change meant, the reasons that she had developed her coping methods. The session was spent normalizing her fear of change. At the end she decided to go ahead, but expressed fear for the future.

In the eighth family session, the boys reported that they were very excited at the time each spent with their mother,

alone. After that auspicious start, David expressed anger that he had to stay in the house and could not go outside to play. Barb was unsure of what to do. She hesitated and did not take any action. David began to cry and yell. Barb did not deal with him. With prompting, she began to question him as to the reasons for his being upset. Matthew began to react in a similar manner to David. Barb tentatively held on to his arm, stroked it and talked gently to him. After she was satisfied with the resolution of the issue, we moved on to another topic. Eventually, both boys fell asleep on the sofa as the session continued. Barb talked about her fear of responding to difficult situations because she was afraid of doing the wrong thing. She was surprised with the feedback that it could appear that she did not care. The love and caring she felt for her children was reinforced for her as well as how well she had dealt with David. Homework was assigned for Barb to arrange family outings with her children in order that they have positive times.

The next four sessions were held in Barb's home without the boys. The first session helped Barb deal with her anger towards Julio, who she felt had abandoned her. She could only intellectualize her anger until she was asked what she would like to do to vent her anger. She replied, rather sheepishly, that she would like to hit him. I played the part of Julio, with a pillow held up to my torso and Barb was given permission to hit. She began tentatively, but with much encouragement and role-playing, she hit with increasing anger and ended up crying

her sadness.

The next session was the follow-up meeting with the school. The psychological assessment had been performed on David. Although we did not have a copy of the report, Barb and the school counsellor had talked with the psychologist. Barb was relieved that the report did not show pathology on the part of her son. She was impressed that her son scored very high on the IQ portion of the testing. Barb agreed to meet with the school and David's new teacher in the fall to allow pro-active planning for David in his new school year.

The next three sessions were with Barb alone and were spent on helping her attack her depression and low self-esteem through cognitive restructuring. She was given chapters in the book, Feeling Good: The New Mood Therapy, to read. Writing down her negative "automatic thoughts", identifying the cognitive distortions and answering them with "rational responses". Barb felt that she was "a failure as a woman because she could not keep a man". She identified that as "all or nothing thinking" and her rational response was that she, "did other things very well, she was a good mother and a good friend. The men that she was so desperate to keep really weren't worth all the effort because they treated her badly." She was able to attack a number of her negative thoughts in that way. Initially, it was very difficult for her to respond to the negative thoughts--she could think of many automatic thoughts but couldn't counter them. With support and guidance, she became adept at recognizing and

answering them.

Family Intervention:

The family intervention worker spent 6 hours per week with Barb and her family. Initially, the goals were to help Barb arrange bed-time routines. The intervention worker was very frustrated at the lack of progress in achieving the goal. Barb did not follow through with the tasks the two practiced together and continued to complain of the boys' lack of compliance. At this point, we might have talked about Barb's resistance or her lack of committment to change. We chose to view the issue from the perspective that we were not addressing the major issue and we reevaluated our goals. Family therapy sessions addressed her fear of change, of failure and how she could meet her children's emotional needs.

The intervention worker then began to point out to Barb when she was doing well at being pro-active with her children rather than merely reacting. She was encouraged to practice in interactions with her sons with the guidance of the intervention worker. It was often as simple as repeatedly focusing on Barb--asking her what she wanted the boys to do next, were they doing what she wished them to do, what would she have them change.

Interactions with her sons then came more within her control and more rewarding, less of a drain on her. It was very difficult for the intervention worker to support Barb in arranging positive activities--she found it difficult to begin

the process. However, once she was able to experience positive times, there was no stopping her. She arranged outings to the fair, horseback riding, bicycle rides to the park. The intervention worker, who accompanied them, saw that the interactions were becoming much more positive.

Termination:

During the last three weeks of involvement, the intervention worker was needed less and less. That signaled the end of the program. Barb had taken the goals to heart and was now performing them on her own.

It was clear that Barb was interacting more as a parent with her sons. She was happier with the interactions and the boys were more relaxed. They described that things were better at home, "happier and less mad". Although there was no dramatic improvement in her housekeeping, the house did become slightly neater.

Barb did not want the program to come to an end. She was reliving her fear of abandonment and we discussed her difficult time with goodbyes in her life. We arranged a picnic/barbeque in the park with Barb and her three children. The goodbye ritual was very important for her and her children. Barb wanted to work on some personal issues and contracted with me for 4 extra sessions after the end of the program.

Barb did have a considerable amount of family of origin work to complete which would require further work.

The H. Family: "A victim in my own family"

Deb H., aged 44, was a single mother of two girls, aged 16 and 10. She and her physically abusive husband had been separated four years earlier and were presently going ahead with a divorce. Her oldest daughter was violent and out of her control. She was concerned that the older daughter's behaviour was beginning to negatively affect the younger girl. The older daughter had been placed in the Manitoba Youth Center in November of last year as a result of an incident in which she punched and knocked down her mother's boyfriend who died several days later.

Assessment:

Deb was a young looking woman--she could have passed for the sister of her daughters. She was very tentative and uncertain, used the phrase, "I don't know..." frequently. Her family genogram indicated that Deb was the child of an alcoholic father. She had a history of physically and emotionally abusive, alcoholic liasons in her life. She took the position of the placator--always making peace and trying to smooth things over. Her older daughter was acting out the anger in the family. Deb's ecomap indicated stressful relationships in all areas of her life. She was on welfare, relationships with her ex-husband and her family were conflictual and unsupportive, her children were out of her control and her boyfriend had died the previous November.

Deb was uncertain of herself, and her children easily convinced her not to follow through on her attempts at

disciplining. The older daughter was often the 'enforcer' in Deb's disciplining of the younger girl--the older girl explained that she had to intervene "because mom always backs down". In spite of Deb's insistence that the older daughter was the problem, at our first session, the younger daughter was very defiant and provided a perfect opportunity for Deb to practice new techniques of child management.

Contracting:

We agreed to meet for 10 sessions. The following goals were identified: 1) helping Deb deal with the older girl's aggression, 2) helping Deb deal with the younger girl's behaviour, 3) Deb wished to work on her grief at the death of her boyfriend 6 months previously.

Treatment:

Family Therapy:

Treatment consisted of examining Deb's family patterns, her relationships with men, and gaining insight into the effects of being the child of an alcoholic family. She was validated for what she was doing well, which surprised her. She became more confident in dealing with her children and was able to tell the older daughter that she did not need her to help parent the younger.

She enrolled in a grief support group and found the courage to find out why her boyfriend had died. She had never made inquiries because she was afraid that her daughter's assault had contributed to his death. She found that he had died from a

heart attack as a result of years of alcoholism and a history of ill-health. She described it as "if a weight had dropped from my shoulders". Deb began to evaluate her relationship with him more objectively, ceased to idealize him, began to talk about his abusiveness and took all but one picture of him out of the living room (there had been five). She arranged for individual counselling and began work on personal issues that she wished to begin resolving.

Family Intervention:

The two goals for the intervention worker were to help Deb practice consistent child management techniques with her younger daughter, to begin looking at age-appropriate ways for the older daughter to differentiate from the family, to help Deb access community resources, and to find supports for Deb and her grief resolution.

The intervention worker helped Deb to look for a support group--she did not arrange it for Deb, Deb was the one who had to be motivated enough to want to make the arrangements.

The F. Family: "Monkey-in-the-Middle"

Assessment:

Darlene F. was a 30 year old divorced mother of a 14 year old boy, Sam. She was presently receiving unemployment insurance and was looking for work. They had been involved with CFS for the past two years. The boy was defiant and aggressive both at home and at school. His mother had begun demanding that he be placed out of the home. Although she and her physically abusive husband had been separated for nine years, there was, still, considerable anger between them.

Sam had no concept of the boundaries between himself and others. He would often express physical affection towards his mother that bordered on sexual; sometimes she would accept the gesture, at other times, she would voice annoyance. The CFS worker had reported that they were aware that, on occasion, Sam slept in Darlene's bed. She denied that there was any sexual behaviour between them. There was evidence that Sam appeared to be replacing his father as his mother's spouse.

Sam was very upset by his relationship--or lack thereof--with his father. His mother would insult his father and fight with him when they were in contact but then insist that she would not prevent Sam from seeing his father. Sam described this triangulation as feeling like "the monkey in the middle".

Contracting:

We contracted for 10 family sessions. The goals identified were: 1) to help Darlene to stop the fighting between her and her

son; 2) to help Darlene learn new ways of managing her son, and; 3) to help Darlene find work and access community supports.

Treatment:

Family Therapy:

A genogram indicated that Darlene came from a large Italian family in which the children really raised themselves and in which the boundaries were not very clear. Darlene had moved from Ontario to get away from her intrusive family. Her ecomap indicated stressful relationships with her ex-husband. She was looking for work, was not dating anyone and felt lonely. However, she belonged to a bible study group from which she derived support and strength and had one very close friend with whom she could confide.

She was helped to acknowledge that her son did perform a lot of work around the house and to have more realistic expectations of him. She was encouraged to define her boundaries more clearly. She began to treat Sam more as a son and less as a partner. During one very hot spell of weather, he asked to sleep with his mother because she had the only fan in her room and she allowed him to sleep on the floor. She no longer allowed him to sleep in her bed.

Sam was encouraged to write his feelings and wishes for their relationship to his father. After many attempts we were able to arrange for him to meet with his dad and talk about how hurt he was that his father saw him so irregularly and how jealous he was of his half-siblings. His father told him he

loved him as much as the other two boys. During many phone calls prior to the meeting, his father was helped to understand how caught Sam was between his two parents and pledged to try to prevent that. He was a mistrustful man who did not "believe in counsellors" and refused to meet in an office. As he lived out of town, our meeting with Sam took place in his van in a restaurant parking lot. If we had not been flexible enough to meet in that way, Sam would never have had the opportunity to communicate with his dad with our facilitative/supportive assistance.

Darlene was helped to extricate herself from the relationship between Sam and his father. She decided to no longer be the go-between in arranging visits. Sam could no longer blame her if his father did not keep a promise, or neglected to contact him, as he had in the past. She told Sam that though she would not be part of the triangulation, she would be there to help him to deal with any of his feelings regarding his relationship with his father. Sam no longer had to mirror whatever emotion his mother generated.

Family Intervention:

The intervention worker spent eight hours per week, focusing on boundary issues and constantly reminding Darlene when she was blurring the boundaries with her son. If he hugged her inappropriately, the worker would ask Darlene if she felt comfortable with what she was feeling. The worker shared her own impressions and feelings at such times in order to model clarity

for Darlene.

Intervention also focused on the confused feelings that Sam had. He would divert the conversation from the issue at hand--his anger at his father's not phoning--and involve Darlene in a fight. She was helped, by the intervention worker, to identify his feelings for him and give him more appropriate options as to how to vent them--rather than taking them out on his mother. One evening, he went out to the pond behind the apartment with his baseball bat and hit rocks across the water for two hours. Prior to that, he would have set up a fight with his mother.

The W. Family: "Don't expect me to tell you I love you"

Mona, aged 46, and her two children: Paul, aged 15; and Vanna, aged 16; lived together. Mona's estranged husband had died three years ago, after being charged with assault by Mona and Vanna. Mona's boyfriend, Bob, was very committed and involved with the family although he did not live with them. They were talking about getting married next year. The children liked and accepted Bob. Mona felt that her children were unmanageable; Paul was on probation and had been fined on a drug charge at Christmas, Vanna was defiant and aggressive and Mona was feeling that either or both of them would have to be placed out of the home.

Assessment:

A genogram showed that Mona had been a victim, first of fondling by her grandfather and father and then of emotional abuse by her alcoholic husband (he was physically abusive when drunk). She had learned to hold in her emotions and although she and Bob were attending an 'Emotions Anonymous' group, she was only able to express anger. Her other expression was that of repressed tears--any subject raised would end up with Mona crying angrily. Her daughter was mirroring that anger in an attempt to get positive recognition from her mother. Both Paul and Vanna were reasonably normal adolescents. They were relatively responsible and were not as 'bad' as their mother presented. Bob tried to be the peacemaker between Mona and the children and between the children themselves. Paul was disengaged and stayed

out of most interactions, if he could.

Contracting:

We contracted for 10 sessions. The goals identified by the family were: 1) to help the family members to communicate better by expressing more positive emotions; 2) to help the family members to avoid fighting and; 3) to help Mona allow her children appropriate responsibility given their stage of development--maturing into young adulthood.

Treatment:

Family Therapy:

Although the family presented with a very emotionally volatile tone, they were unable to resolve issues during their interactions. They expressed primarily anger. As the family was given the opportunity to acknowledge their feelings, particularly the more vulnerable emotions such as sadness and affection, Mona's repressed tears ceased, the tone became much warmer and more accepting.

Mona was able to express her fear of being vulnerable and cited experiences from her past that caused her to be wary. The children claimed that she was blaming them for things for which they had no responsibility. Mona was given a piece of paper with 'MONA'S PAST' written on it. Her homework assignment was to produce the paper every time she felt the past intruding on the present. It became a password for the entire family when they felt that she was bringing in issues with which they had had nothing to do.

Vanna expressed, with tears, that it upset her when all she ever heard were negative things from her mother about her deceased father. She talked about how her father's family blamed her for his death, because of the assault charge. Her mother apologized for dwelling on her negative memories and began to talk about more positive memories of him. However, Mona needed much support and encouragement to comfort her sobbing daughter. Instead, she talked about her own fear of rejection--but ended up holding Vanna, tightly. At a subsequent session, Paul cried that he loved his mother, but felt left out of the family. Mona was encouraged to comfort him as well.

Considerable time was spent on encouraging Mona to express positive emotions. She found it very difficult to give praise, continually couching her comments in the third person even while talking directly to the recipient. Bob learned from the sessions how to encourage her and he asked her to do the same for him.

Family Intervention:

The intervention worker spent six hours per week focusing on helping the family to recognize interactions when Mona was reacting to the past rather than the present. The worker helped train the entire family to cue one another. The second focus was on helping Mona recognize the positive aspects to a situation and give positive feedback. It sounds like such a simple task, but Mona's negative focus was deeply entrenched and required hard work to dislodge.

The C. Family: "A victim of the system"

Stacy C., aged 28, and her two children; Grant, aged 6 and Tammy, aged 9, lived with Charlie, aged 28 (Stacy's boyfriend of three years). There was much community concern regarding her son who had been badly burned three years ago and was difficult to manage at his day care. Tammy and a friend had been sexually fondled by a neighbour a year ago. The girls had to prepare to testify although the man had pled guilty, unexpectedly.

Assessment:

In-home sessions indicated that Stacy was a very appropriate parent. She was more than adequate in her physical and emotionally care for her children. Charlie was a very peripheral step-parent. The major issues were with Stacy's and Charlie's relationship. Stacy was the eldest child of an alcoholic father and had been a parental child who learned to take care of herself and everyone else. She was very verbal and overwhelmed inarticulate Charlie with her self-proclaimed honestly and ability to state her feelings. In reality, she was afraid of intimacy and could not allow Charlie to care for her or become too much a part of her life.

A genogram indicated that Stacy came from a disengaged alcoholic family. She was separated from her extended family who lived in B.C. (her mother was dead). Stacy described herself as the parental child--she was the oldest of three. She welcomed information on the issue of being the adult child of an alcoholic.

One of the most interesting dynamics regarding this family was the number of professionals who had been meeting about them on a monthly basis for the previous eight months. There were (including the intervention worker and myself) fourteen people involved. This included: four day care people, a public health nurse, several people from social services at the Children's Hospital, a psychiatrist, a school social worker and the CFS worker. The meetings had begun out of a need to coordinate the growing body of service-providers. They had begun meeting out of a concern regarding Grant's medical needs, his unmanageable behaviour at day-care, and Tammy's disclosure of third-party sexual assault. The group had consistently decided that Stacy would have been "intimidated" by the group and chose not to invite her, nor to inform her of the meetings. At the commencement of this program we were invited to a meeting and we agreed to go if Stacy could accompany us. The group chose not to include her so we declined the invitation. Members of the group were annoyed and expressed their anger to the CFS worker.

Treatment:

As this family was referred later in the program, we worked with them for six weeks as opposed to the intended twelve week length of the program. We helped them to identify the marital issues between them and they agreed to begin working on these issues. The intervention worker spent six hours per week helping Stacy and Charlie to begin working on communication and identifying their feelings and desires from the relationship.

They were able to continue receiving in-home therapy with the psychiatrist who had been part of the original group. The psychiatrist was the chief resident at the Children's Hospital and was offering the special in-home service. Our last meeting with Charlie and Stacy included the psychiatrist and effected the transfer.

A major task performed was that of getting the group to meet together with Stacy in order for her to meet the people who were involved with her family. We invited the 12 people to our discharge conference and seven of them attended. We were able to summarize the issues to those present, and arrange for Stacy to attend the next meeting.

CHAPTER V

EVALUATION

At the first session (after the initial information giving meeting), and subsequent to the family agreeing to work with us, the FAM III General Scale (Skinner, Steinhauer and Santa-Barbara; 1983; Appendix C) and a Problem Checklist based on a scale from the Morrison Centre in Portland, Oregon (Trute, 1985; Appendix D) were administered to the family members. As well, a child Direct Observation Form (Magura, Silverman and Moses, 1986; Appendix E) was filled in by the family intervention worker. These measures constituted the baseline and were all administered again, during the termination session. The measurements were intended to determine if the treatment would have an effect on self-perceived family functioning, on the problems as each member saw them, and on the observed behaviour of the children.

The parents and children of five families completed the program--a total of seventeen individuals. All parents (seven in total) and the children over the age of twelve (four) completed pre- and post-treatment measures. For all the children involved (ten), the intervention worker completed pre and post treatment observation forms. The data from each measure will be reviewed and the respective strengths and limitations of each measure will be outlined.

The involuntary nature of the client population was an important consideration in the choosing of instruments. Although the families agreed to participate in the program, for several of

them, it was a grudging acquiescence. Three of the adolescents were very fearful and manifested anger and many threats to drop out, althought they did take part. The measurements used had to be short and easy to administer in order to have the instrument not become the focus of apparent resistance.

Verbal self-report/feedback and post-treatment measures indicated that all of the families felt that they had benefited from the program. In every family, the parents indicated that they wished that the program would continue, one family (the W's) said that they would miss us even though they did not feel that they needed us any longer. Only the children in the H family did not feel that they had benefitted from our involvement, even though their mother did. Barb R contracted with me to continue individual counselling for four more sessions. Not only did each of the families report benefits from the program, but we were able to see positive changes in the interactions of every family.

In two of the families (the C and H families), further work was required after termination of the program. The families agreed and the evaluative tools confirmed that decision. Both were able to be connected with approp riate therapists.

The Family Assessment Measure--FAM III:

It is very difficult to find instruments to measure the many variables impacting on a situation when you take an ecological family systems perspective. Most standardized instruments are designed to measure specific, behavioural concepts. The FAM III

(Skinner et al., 1983), developed out of the Process Model of Family Functioning, is an inventory based on Canadian norms, for both clinical and nonclinical populations (Trute, 1985). It has separate norms for adults and adolescents. It has reliability coefficients ranging from .86 to .95. This measure includes three scales; a Dyadic Relationship Scale (42 items, seven subscales), a Self-Rating Scale--each individual's perception of their functioning in the family--(42 items, seven subscales) and the General Scale (50 items, nine subscales).

The General Scale (Appendix C), which can be used independently of the other two scales, was selected for use in the present practicum. On the General Scale, family members identified their views of their family. The General Scale has internal consistency reliability estimates ranging from .62 to .93 for adults and .60 to .94 for children. This measure was chosen in an attempt to give the family members the opportunity to describe their *family* functioning, rather than just describe the identified patient or the problematic behaviour. The General Scale is a paper and pencil test which takes approximately twenty minutes to administer.

Examples of questions from each subscale of the General Scale are:

Role Performance: Family duties are fairly shared.

Communication: I never know what's going on in our family.

Control: Punishments are fair in our family.

Affective Expression: I can let my family know what is

bothering me.

Task Accomplishment: We spend too much time arguing about what our problems are.

Involvement: My family tries to run my life.

Values and norms: We are free to say what we think in our family.

Social Desireability: I don't think any family could be happier than mine.

Defensiveness: We never get upset with each other.

Each item was answered on a four-point likert-type scale, pegged Strongly Agree at one end and strongly disagree at the other end.

Problem Checklist:

A problem checklist (Appendix D), recording the level of satisfaction of family members in a number of specific areas of concern, was also administered pre and post-treatment. This checklist was based on one designed for The Morrison Centre for Youth and Family Service in Portland, Oregon (Trute, 1985). This client system self-report was easy to administer and gave a very clear picture of the change in various behaviours from pre to post-treatment.

Examples of questions from this scale are:

1. Showing good feelings (joy, happiness, pleasure, etc.)
14. Relationships between parents
17. Time family members spend together

The questions were answered on a five-point likert-type scale pegged very dissatisfied at one end and very satisfied at the

other.

Child Behaviour Checklist:

"The Child Behaviour Checklist (CBCL) is a standardized instrument to measure detailed behaviours of disturbed children (Magura, Silverman and Moses; 1986). It consists of 118 behavior-problem items and seven social competency items which are organized into six different sex-age profiles: male and female , aged 4 to 5 years; 5 to 11 years; and 12 to 16 years. Norms were obtained from random interviews with parents in the Washington D.C. area. Test-retest reliability ranged from .82 to .90 from testing one week apart. Inter-rater reliability ranged from .54 to .79.

The entire CBCL consists of five separate forms: a Teacher's Report form, a Direct Observation Form, a Youth Self-Report and two Child Behavior Checklists to be filled out by the parent (one for ages 2-3, the other for ages 4-16). The parents of the families who took part in this practicum all shared a tendency to focus on the children as; having the problem, the cause of family difficulties, too demanding or angry or defiant. To avoid the tendency that many parents in this study already had, that is, to blame children and see them as the problem, the Direct Observation Form of the CBCL was employed and completed by the intervention worker.

INDIVIDUAL DATA

On the FAM III General scale,the evaluative results indicate that there was a trend towards improvement from pre to post-test

in all but two of the families. Averaging of the data for the parents of the five families shows that, in general, the trend at post-treatment shows improvement (Appendix G). There was a negligible increase in the values and norms subscale at post-testing. Charlie C. had reported a very low score in this category on his pre-test, which pulled that score lower in the pre-test average. Clearly, the average scores indicate an improvement at discharge from the program.

The data from the Problem Checklist demonstrated a slight improvement in all cases from pre to post-test. The family members all appeared, from this measure, to have been more satisfied with their family when the program terminated.

The data from the CBCL was not usable. This will be discussed further at the end of this section.

In general, the test results indicated evidence of a trend, with family members reporting improvement from pre to post-testing. The evaluation results will be discussed on a family by family basis.

R FAMILY:

Barb:

On the FAM (Appendix H1), pre-treatment, Barb indicated concern on the areas of role performance, communication and control. Her role performance scores reflected how she needed her children to meet her needs (and how she could not mother them), her messy house (she was not a good housekeeper, thus, she was not a good woman), and her fear of 'doing the wrong thing'

(she chose not to actively discipline her children rather than intervene wrongly). Rather than not caring (as it appeared), she was merely overwhelmed by the responsibility of and fear of failure in her role as mother. Her oppositional struggle with the CFS worker was evidence of her problematic control score. She scored somewhat low on the defensiveness scale, showing that she was a very defended woman. Social desirability was also somewhat low as compared to the rest of her scores--she did want to do what was socially acceptable. At post-treatment, both scores are more in keeping with the rest of the scores. Barb saw considerable improvement in task accomplishment (from 58 in the average range to 38 in the strength range). All of the other areas improved, as well.

On the Problem Checklist (Appendix H2), Barb's scores on the areas of 'showing and sharing feelings' improved from 'dissatisfied' to 'very satisfied' at post-treatment. Scores on 'time family members spend together', and 'discipline' also showed improvement. Her score on 'feeling good about yourself' changed from 'dis-satisfied' to 'satisfied'. Her scoring of 'finances' (she was on welfare) and 'housing situation' as 'in between' post-treatment. Those issues were out of her control and treatment had not changed those issues.

W FAMILY:

All four members of this family reported their perception of their family as having improved on both the FAM and the problem

checklist, from pre to post-treatment.

Mona:

On the FAM (Appendix J1), Mona's major difficulty in expressing her more tender feelings was clearly shown by her highest problematic affective expression score. Higher scores in the area of communication was reflective of her inability to communicate with her children as her past issues prevented her from trusting them. The problematic involvement scores reflected her concern regarding her older two sons' disengagement from the family, her younger two growing up, and her fear that the younger ones' moving out of the family would mirror the detachment of the older two. Mona felt uninvolved in their lives. Those were the areas in which she identified problems to the social worker. Post-treatment, her scores were all within the average range with no scores in the problem range.

All of Mona's scores on the Problem Checklist (Appendix J2) indicated an improvement at post-treatment, particularly in areas such as 'sharing feelings', 'sharing problems', 'time family members spend together'. Her overall ratings of her 'satisfaction with my family' and 'feeling good about myself' both improved at termination.

Vanna:

Vanna, aged 16, reported no major concerns on the FAM (Appendix K1) except for task accomplishment and involvement which were slightly in the problem range pre-treatment, but

which dropped into the average range, post-treatment. Vanna's concerns were that she was the one who was always blamed when the house was messy and that her brother did not do his chores. She said that she tried to keep her life separate from the family--particularly her mother--and that her mother really didn't know her. During treatment, as her mother began to acknowledge Vanna's strengths and not just get angry with her, she began to share more with her mother.

On the Problem Checklist (Appendix K2), Vanna's scores improved in the areas of 'sharing problems with my family' and 'time family members spend together'. Her post-treatment scores were mostly in the 'satisfied' category. In the category of 'feeling good about myself' also improved.

Paul:

Paul's pre-treatment scores on the FAM (Appendix L1), indicated major concerns on all subscales. Involvement was the only subscale on which he scored in the average range. His post-treatment scores, except for role performance, moved down into the average range. Paul was very uncertain in social situations and within the family. One moment his mother would be angry with him for not performing his chores and the next moment she would be affectionately smiling at him as 'her baby' for the very same reason. He and his sister had normal sibling ups and downs but Vanna was very emotionally powerful and he would withdraw when he felt overwhelmed by her affect. As well, the family pattern had been for the boys in the family to leave after

years of conflictual interactions with parents. Paul was not following that pattern and may have been questioning where he stood. His mother had a boyfriend, so he wasn't needed to be the man of the house. Interestingly, his initial defensiveness and social desireability scores were much lower than his other scores. That was evidence that Paul focused on appearing to function better than he actually felt or that his scores indicated.

On the Problem Checklist (Appendix L2), Paul's post-treatment scores improved in almost every category, particularly 'relationships between children', 'relationships between parents and children' and 'sharing problems with the family'. His overall satisfaction with his family and himself also improved at post-treatment.

Bob:

Bob's scores on the FAM (Appendix M1) indicated a slight drop into the average range from pre to post-treatment. However, his pre-treatment scores on social desirability and defensiveness were unusually low. This bears out the observation that, initially, Bob was the peacemaker, always trying to make everyone feel happy or better--wanting to do the right thing and make everything run smoothly. His post-treatment scores indicate less artificially low scores. He felt freer to express his concerns after having seen the family express emotion, and the subsequent closeness that more effective sharing had wrought. In the pre-treatment testing, his concerns in the problem range were

communication and affective expression. He wanted the family members to communicate better but felt uncomfortable with the anger and lack of resolution. He identified that he found Mona's anger and negative outlook frustrating. After Mona was able to balance her anger expression with more positive emotions, his post-treatment scores dropped to the average range.

Bob's pre-treatment scores on the Problem Checklist (Appendix M2) were variable. His scores improved in all the categories that dealt with 'showing and sharing feelings', and 'relationships between children, parents and between parents and children'. His overall rating regarding the family improved, while 'feeling good about myself' went down one category. He had felt that he had no problems prior to treatment but some issues dealt with caused him to say that he needed to work on positive expression of feelings as Mona did.

F FAMILY:

Darlene:

Darlene showed general improvement from her pre to post-treatment scores on the FAM (Appendix N1). However, scores remained the same--very high--on both tests for role performance and involvement. Those subscales reflected major issues for Darlene--her lack of differentiation between her and her son, Sam; and the nature of their relationship--was he her partner or her son? As well, she had not dated seriously in the eight years since her divorce--she felt insecure in her sexuality. Task accomplishment increased at post-testing. The greatest

improvement occurred on her communication and control subscales. As she and Sam learned to communicate about their feelings and as she began to understand what was and was not age-appropriate for Sam, she altered her expectations of him and the control problems lessened. She scored unusually low on the defensiveness scale on both tests--although her social desireability score did move more within the normal range at post-testing. The low defensiveness score might indicate Darlene's need to overstate the seriousness of her family issues.

On the Problem Checklist (Appendix N2), Darlene's scores improved notably. Improved scores in the categories that dealt with showing and sharing feelings reflected a more open communication in the family. Scores on 'relationships between parents and parents and children' and 'time family members spend together' were higher at post-testing. Darlene's feeling about herself improved from pre-testing. the pre and post-test.

Sam:

On the FAM (Appendix O1), Sam's score did not significantly change from pre to post-treatment. Sam's scores moved slightly into the problem range. Sam was, initially, very unwilling to participate. He refused to complete the pre-test forms at the first session, but, with reluctance, acquiesced. He said that he would just answer anything to get it over with. That may reflect the similarity in scores.

On the Problem Checklist (Appendix O2), Sam's scores dramatically improved at post-testing. Of particular note, was

the improved score in the category of 'relationships between parents, between children and between parents and children'. His overall satisfaction with his family and himself improved as well. An explanation for why the Problem Checklist reflected such an improvement, unlike the FAM, was that Sam found the Checklist easier to answer and therefore, he paid more attention to it.

The next two families, as mentioned above, identified issues that required further treatment--marital and individual issues. Their scores reflect this very clearly.

H FAMILY:

In the FAM scores of this family, there were no clear trends of improvement at post-testing. For Deb, the mother, treatment helped her identify personal issues for which she needed further counselling. She joined a support group for people who had experienced separation, death or divorce. Prior to discharge from this program, she had arranged to begin seeing another counsellor.

Deb:

Deb had a slightly lower overall rating on the FAM (Appendix P1) at post-treatment, although it was still in the problem range. Her task accomplishment, affective expression and involvement scores improved at post-testing and can be interpreted as indicatative of Deb's increased feeling of mastery as she found she could manage her younger daughter's

behaviour. She relaxed her rigid expectations of her children's lives and was able to express herself more effectively and involve herself in her children's lives in a much less antagonistic manner. Her scores on the role performance and control subscales moved up into the problem area at post-testing. The control scores were reflective of Deb's identifying her victimization in the abusive relationships in which she had engaged. She was experiencing the developmental issues of her oldest daughter (aged 17) maturing into adulthood as well as her younger daughter growing into adolescence--and the accompanying role confusion this created.

On the Problem Checklist (Appendix P2), Deb reported slight improvement. Her scores on 'handling anger and frustration', 'relationships between parents and children' and 'time family members spend together' all improved. Also improved was her 'overall satisfaction with family', while her feeling about herself did not change from pre to post-testing.

Tara:

Tara's overall rating on the FAM (Appendix R1) stayed in the average range from pre to post-treatment. At pre-treatment, her scores on affective expression, involvement, control, and values and norms subscales were just slightly in the problem range. Tara believed that there was no need for family therapy and that the family was fine. Her scores on the social desirability and defensiveness subscales were considerably lower than her other scores which indicate her reluctance to acknowledge any problems.

However, as her mother backed away from their power struggles and allowed Tara to differentiate from her family as all adolescents need to do, Tara reported problematic scores in role performance and affective expression at post-testing. As Deb became stronger as a parent to Kristie, she did not need Tara's support. This left Tara feeling that her role in the family had changed, with no blueprint of what it would now become.

On the Problem Checklist (Appendix R2), Tara reported a general trend of slight improvement in her scores in most categories. The only lowered scores were 'family finances' and 'use of physical force'. She was frustrated with the fact that her mother was not as forceful with Kristie as her parents had been when Tara was her age. Her overall rating of her feeling about her family about herself also improved at post-testing.

Kristie:

The authors of the FAM recommend that it should only be administered to children over the age of twelve. Kristie was ten years old, but answered both questionnaires. The results may not be accurate. Her post-treatment overall score (Appendix S1) increased, although they did remain in the average range. Kristie, certainly, did not perceive problems prior to treatment. She saw her sister as the one with the problem. As treatment progressed, and her mother began to be more consistent and firm with Kristie, she reported increased problematic scores in role performance, communication, affective expression and control.

Kristie's pre and post-treatment scores on the Problem

Checklist (Appendix S2) were quite scattered. She showed a deterioration of scores in the categories of 'making sensible rules', 'time family members spend together' and in her overall satisfaction with her family. Her mother was less socially isolated and was managing Kristie's behaviour more consistently. She did report higher scores in 'handling anger and frustration', 'amount of independenc in the family' and 'making contact with friends, etc.', as well as a very strong improvement in her feeling about herself. Although she fought her mother's clearer definition of boundaries, Kristie felt more secure as a result.

C FAMILY:

Both Stacy's and Charlie's FAM scores increased at post-testing. However, their overall ratings fell within the average range at both testings. As with the H Family, Stacy and Charlie became aware of issues during treatment which neither acknowledged before treatment. They decided to seek, and arranged for, marital counselling upon termination from this program.

Stacy:

All of Stacy's scores on the FAM (Appendix T1) increased (task accomplishment, communication, affective expression) or remained the same (role performance, control, values & norms) from pre to post-treatment. The increased scores suggest that she was frustrated because Charlie did not help her around the house, would not communicate and they were unable to express (or, even, identify) their emotions. These issues became evident

during therapy. The only decreased score was that of involvement--she was pleased that Charlie was engaged in the treatment process and was committed to being a part of making their relationship better.

On the Problem Checklist (Appendix T2), Stacy's pre-treatment scores covered all categories. Although her overall satisfaction with her family and feeling good about herself improved slightly at post-testing, there was only a very slight general trend towards improvement. The Checklist was not as accurate a measure as the FAM at identifying the salient issues.

Charlie:

Charlie scores on the FAM (Appendix U1) presented him as a man who did not see many problems in his relationship with Stacy. His pre-treatment scores reflect his view that his family life was very positive. He was a disengaged man who went to work and didn't deal much with the children because they weren't his, they were Stacy's from previous relationships. However, as treatment progressed into the third session, Charlie was ready to leave the relationship as he was forced to confront his "head in the sand" approach with Stacy. Post-testing showed an increase in all scores except for affective expression, which decreased. Therapy was able to help Charlie and Stacy express vulnerability, affection and healthy anger towards one another, something they had been unable to do before. At post-treatment, Charlie indicated problems with task accomplishment and values & norms,

which had been in the average range pre-treatment. Task accomplishment was also a problem for Stacy, who rated it in the problem range both pre and post-treatment. Household routines were always a major frustration for Stacy, while Charlie did not see it as an issue. However, post-treatment showed that he had begun to see it as a problem as she did.

On the Problem Checklist (Appendix U2), Charlie's answers showed general improvement from pre to post-treatment. However, his scores deteriorated slightly in categories such as 'sharing feelings', 'making sensible rules', 'being able to discuss'and 'dealing with matters concerning sex'. They had always described the sexual part of their relationship as having no problems. They had both become less compartmentalized in their relationship as both Charlie and Stacy reported a drop in score in that category at post-testing.

Comments on the Evaluation Tools

Administering questionnaires in the family's home, especially prior to the forming of a relationship was a difficult aspect of the evaluation process. It was particularly difficult to convince those adolescents who expressed hostility towards the entire treatment process to fill out the initial questionnaires. There were many distractions and attempts to avoid the task, which was made easier because assessment was in their homes.

The FAM III was an easy test to administer, quickly tabulated and easily interpreted. The graph is a very effective

way to see the comparison between pre- and post-testing. The ability to compare scores to standardized norms was very helpful. Some of those who filled out the questionnaire found some of the questions repetitive. There were also some complaints that it was difficult to choose between the answer categories. Respondents often wanted a category between the 'agree' and 'disagree' answers. In spite of that, the families found the results of the tests fascinating and seemed to make many connections between the subscales and their experiences.

The Problem Checklist was an even easier questionnaire to administer. Visually, the comparison between pre- and post-testing was immediately apparent, but the trends were not as clear as the FAM. However, the test is not standardized and deducing the pre and post-test changes can only be visually accomplished and is not as clear as the FAM.

As mentioned previously, the Direct Observation Form was a complicated tool to administer. The measure has two facets that made the data unusable in this case. It appears to be a tool more geared towards a structured environment such as a classroom and it seems to have been designed for children who are identified as emtionally disturbed. The items to be scored by the intervention worker were specific to behaviours that might be considered in the nature of a 'conduct disorder', so the 'normal' children that we observed rated many 0's (item was not observed) during both pre and post-testing. The form that I chose for a direct measure of child behavior contained a category of being

'on task' or 'not on task' which did not fit for the unobtrusive observation required for the observation period. The worker could not arrange for the child to be on task during the observation period, because in the home, tasks are not so formalized. The scoring also recommends comparisons between the observed child and two control children. All of the children in the home were being observed, so a control group was impossible to obtain.

At the onset of the practicum, I had planned that these instruments could be incorporated into the treatment process. The issues identified in the pre-treatment testing could have been used as the treatment goals on which to focus. However, I was not familiar with the instruments or how potentially accurate they could be at identifying the treatment issues as I forged ahead with the goals identified in interviews with the family and mutually agreed to as the focus of treatment. For example, Darlene F's extremely problematic score on the control subscale remained the same from pre to post-test. If the measure had been part of the treatment process, that issue of control would have been highlighted.

In this practicum, the instruments were utilized solely as indicators of pre- and post-treatment changes. Although the measures were not used to guide the treatment process, in retrospect, it was very interesting to note that most of the problematic areas indicated on the FAM were, most often, the very issues identified as therapeutic goals during treatment. Barb R

was very concerned regarding her role performance. Her perception that she was ineffective as a woman and a mother was clearly indicated by her FAM scores. Mona W's extremely high affective expression score at pre-testing reflected her difficulties communicating vulnerable emotions. The FAM is an accurate predictive tool (of therapeutic goals) as well as a measure of outcome. I plan to continue the use of it in my future work.

CHAPTER VI

SUMMARY AND RECOMMENDATIONS

In this section, I will discuss questions and conclusions that have arisen for me during the process of providing services to families in their homes.

This practicum was not intended as an empirical research study. The two functions of family therapist and family intervention worker, although differentiated between conceptually, were not operationalized separately for experimental purposes. The design of this program does not demonstrate the effectiveness of the particular components of the program--for example, did the family therapy component have more or less of an effect than the family intervention piece? The lack of concise evaluative tools and the myriad of variables would appear to make such a task daunting. The measures do, in general, show the families' perceptions of positive changes in their families, after treatment.

Although research has begun to demonstrate the positive effects of support networks on individuals and families who present with difficulties (Garbarino et al, 1980; Trute and Hauch, 1987), no equivalent research on the professional family support/intervention role appears to exist. It is my premise that the needs of such families involved in the child welfare system require a program of treatment (i.e. family therapy) as well as the added component of intensive in-home intervention in order to effect change. In this practicum, the role of the

family intervention worker is one facet of the entire range of what is effective in the realm of family therapy. The two functions--family therapist and family intervention worker--exist within a whole body of knowledge of practice. Goal setting and effecting structural (process) changes with the entire family is the functional manifestation of a systemic perspective. It is arbitrarily called 'Family Therapy', not because of some intrinsic superiority on the part of family therapy, but because family therapy makes the change in the family structure while the intervention task is to support that change.

The task of the intervention worker falls within the territory of the family therapist. The function arbitrarily named 'Family Intervention' is geared towards a more content oriented role of helping the family to translate the structural alterations (meta changes, if you will) to their 'real world'. At times the two roles are indistinguishable and at others the distinctions are very clear. The family therapy goals are the foundation for the task of the intervention worker. The two must work very closely to ensure that they function with complementarity.

KNOWLEDGE GAINED

One of the powerful tools that worked for both the therapist and the intervention worker had was that of our own experience, perception, and intuition. An ability to use whatever works at the time, seemed to be most effective. The intervention workers

found that they were encouraged to be free to use their emotions and their 'guts' in their work with the families. First, they had to spend time identifying what were the roots of their frustrations, 'stuckness' or anger, in order to make constructive use of it. The intervention workers could then empathize with the difficulties of the families as they both struggled to make sense of their own process. The intervention workers provided an effective model of how to use that process for the families.

However, I was able to develop specific skills and ideas regarding how to implement in-home treatment during this practicum, which focused on treating families, their individual members and the service providers in the families' larger systems. The work, itself, involved reestablishing proper parent-child hierarchies, dealing with triangulation issues and focusing on proper role performance and family of origin issues which intruded into current relationships. Although these tasks derive from systems theory, the instincts of the individual became an important therapeutic tool.

At the beginning of this practicum, I identified one of my isues of concern as the apparent 'resistance' with which some of the families involved with the child welfare system are labelled. I wondered if such a program could reach families who appeared unwilling to work. 'Resistance' is a concept used very frequently with families involved with the child welfare system. We found that families were not 'resistant'; they could more accurately be described as fearful, mistrustful or uncertain.

They were afraid of the unknown--what would happen if things changed in the family? Would people get angry at one another? If one person asked for affection from another, or showed vulnerability, would they be rejected? The mistrust often stemmed from a generalized fear of outsiders, or of 'helpers' who had promised help and had not delivered, or of nosy social workers... The uncertainty came from people who couldn't identify what was wrong or what to do about it and thought the best way to deal with it was to ignore it. Even the most reportedly resistant members had issues and if we could find out what they were and join with them, they would engage in treatment.

In the data collected from the children, it is interesting that their pre and post-treatment scores did not differ as much as the adults. Generally, the children (particularly the older ones) did not see problems in the family as much as they verbalized a need to escape from the family. The adolescents, often, manifested hostility to mask their uncertainty and fear. Seeing them individually, early in the treatment process, would have been helpful to connect with them and hear their story. In my zeal to adhere to systemic precepts, I did not want to see individuals and insisted on the family being seen together. The adolescents described feeling that they were being 'picked on' and they were, most often, the focus of the blame in the family. Meeting individually, early in the treatment process, might have uncovered issues that took much longer to discover in the family

sessions. Later in the process, I could not convince them to meet individually with me although they continued to attend family sessions. Such a meeting with the adolescent alone would be helpful in circumventing their belief that the therapist was siding with the parent against them.

In spite of the fact that all the proper therapeutic techniques were employed, some families were simply not ready to deal with their issues. Families are very powerful systems and can exert powerful checks on even those members who do want help. In-home treatment goes very far towards engaging those families who might otherwise drop out of the treatment process, and also helps to identify the environmental issues (eg. being overwhelmed by single parenting and therefore too tired or depressed to expend much energy on the treatment process, no transportation, poverty, no social or family support, etc.) that might interfere with treatment. Inevitably, some families make the decision not to engage in treatment. Of the initial referrals, approximately one-quarter did not agree to continue after the initial meeting. None of the families with whom we initially engaged, and who agreed to treatment dropped out. This program appeared to meet the needs of and engage these families who had been unsuccessful in other treatment programs.

Dealing with intergenerational issues through the use of genograms was a very important method of helping families and their members to identify the patterns by which they interacted and to change them when necessary. These families all had

chronic difficulties in their relationships with their families of origin. It was amazing to see, time after time, the power of plotting genograms with a family. Many of their apparently maladaptive behaviours made absolute sense when seen within an intergenerational context. At that point, blaming was no longer an issue. Barb R sat back in stunned resignation to see the pattern of emotional and physical cut-offs in her genogram. She whispered, "No wonder I feel so alone!" She then moved on to change that way of approaching the world.

Issues in the Training of Family Intervention Workers:

Working with the family intervention workers was a major part of the practicum. One of the workers was employed by the same CFS agency in which the practicum was set, while the other two worked with a private agency which contracted with CFS to provide family support services. All three of the intervention workers were women. They identified that, in fulfilling their role; regular and consistent direction, the opportunity to debrief, and being supported were very valuable.

The intervention workers described this method of intervention as being very different from how they had previously worked as support workers. As support workers, referrals came to them from social workers with instructions to 'help the family', 'provide the child with a positive experience away from the family', 'help the child fit into the family', or 'support this parent'; with no procedure or supervision to accomplish the directive. One worker referred to her nickname for the job of

family support: "pot-pourri worker". The workers identified that another of their tasks as 'support' workers was to perform assessments of the suitability of a child remaining or returning home--information that conceivably could be used as evidence in court. The conflict of roles would certainly preclude such a worker from performing a therapeutic function if the family was aware that their behaviours were being recorded for a trial. These are the workers who probably spend the most time with a family in a supposedly therapeutic role!

The workers reported confusion between the roles of support and intervention. They would describe engaging the families in family therapy when they did not have the training to be effective. They, often, did too much for their families. Taking over parenting tasks under the guise of 'modelling' was a favoured activity. It was difficult, without being there or seeing video-tapes to be able to know exactly the nature of their work. We were not able to arrange the luxury of a portable video camera to effect such supervision.

All three stated that the striving for objectivity in the ongoing assessment and intervention with the families was also helpful. They described difficulties in conceptualizing the boundaries between the therapist and the intervention worker; for themselves, for the families as well as for other professionals involved. They indicated that a better "orientation of the system" would have been helpful--other agencies and resources were not aware of the philosophy of the program.

Spending time in the families' homes almost guaranteed that the workers became part of the system very quickly. Certain behaviours, reactions or rituals of the particular family become accepted very easily by the workers even though they may have been counter-therapeutic.

In the case of the F family, Sam was so used to the family pattern of triangulation that the intervention worker found herself on one occasion fighting with him as his mother and he used her in a fight about whether he would accompany them to dinner. He did not want to go but did not communicate it clearly. His mother and the intervention worker did not ask for clarity, they waited an hour for him to finish a chore and then he told them that he wasn't going. The intervention worker felt that her behaviour had been unprofessional. However, the exchange did provide valuable therapeutic grist. Mom was able to see an enactment of how she and Sam interacted. Tracking the process was very helpful for Sam's mother to learn to avoid such traps in future. Mom also felt that she was not such a failure as a mother when she got caught, because after all, "a skilled professional, who should know better" got caught, also.

Getting 'caught' in family patterns happened to each of us, with the resulting confusion, frustration and feelings of stupidity. Awareness of this eventuality as well as regular supervision to help regain some degree of objectivity were essential.

Helping them to begin to see from a systemic perspective, to

reframe and be comfortable with process rather than content issues was an ongoing collaborative process. Teaching the workers to trust in 'how' things are done, rather than 'why' or 'what' is being done, was a major task. In my experience, family support workers are, generally, very concrete thinkers who have been taught to take control and keep the peace. In the intervention role, placating and calming was not the desired end. Raising intensity and unbalancing the family system was the important task.

The most rewarding aspect was watching how the nature of their work changed as the intervention workers incorporated a wider perspective in their work with the program. Initially, their effectiveness was restricted by their child focused perspective. They would blame parents for not meeting their children's emotional needs. As they learned from the treatment process through genograms and systemic reframing, they became more tolerant and less blaming. They learned that their work was more effective when they included all family members in their work. They began to look for boundary issues and triangulation patterns in assessing their ongoing involvement. Prior to the program they did not feel they had the mandate to insist that everyone take part in treatment. It was easier to overlook reticent family members. As they learned to reframe apparent 'resistance' as fear or uncertainty, they learned that they could require compliance and were more effective as a result. They also learned to be more comfortable with creating intensity and

seeing it as a healthy process to better family functioning.

The workers described that at the end of the program, when they returned to their 'support' jobs, their work changed as they incorporated the above perspective. One worker quit her job after the end of the program, saying that she no longer could work at a family 'support' position without the family therapy and supervision component.

RECOMMENDATIONS

I recommend that a similar treatment program, as the first line of intervention, be available to all families that come to the attention of child welfare workers. Prior to any discussion of placement (except, of course, in cases where a child is in immediate physical danger) participation in this program should be mandatory. This intervention would replace the staff who 'supervise' or 'babysit' by making all contacts therapeutic. I see such a program existing within a separate treatment unit accessible to the child welfare workers. The tasks of the treatment unit and the child welfare mandate are too complex, separately, to expect that one worker could fulfill both roles.

The family therapist and family intervention worker should work out of the same agency. This would alleviate the role confusion since ongoing training would occur with both workers having the same philosophical perspective and would be able to be clear with other systems--family, social workers, community.

The training of family intervention workers is a major

component of a successful program. There must be information made available on the tasks and role of in-home workers. Sharing the similar experiences of similar programs is essential. Only then can we begin to differentiate between the goals of differing programs and construct appropriate training programs, tailored to specific program needs.

Ongoing supervision is essential if the family intervention workers are to continue to provide effective service. Weekly group and individual supervision is mandatory. Video-taping in the family home is one of the most effective tools to give accurate feedback and support. Many of these families are among the most difficult to treat. They have been through many different systems and professionals and have very complex, entrenched dynamics and we are, potentially, just another stop on their way to being untreatable. Support is essential to prevent workers from developing feelings of defeat in the face of such powerful systems.

This program was designed to be a short-term (approximately three month) intervention. Similar programs must have the flexibility to offer longer term service if the nature of the family's issues warrants it.

Further research is needed to prove the merits of in-home programs. As long as money is being allocated from child welfare budgets to provide family support, the service offered must be comprehensive, goal directed and therapeutically motivated. Child welfare agencies continue to demonstrate a committment to

fund and utilize family support services in spite of the lack of any research evaluating such programs. As with training issues, exchange of information between programs is important--what works, what doesn't? Rothery and Cameron (1985) note that this information is currently unavailable.

Clearly, defining theoretical perspectives for in-home programs as well as specific programming for different client groups is necessary in order for service to improve. Identifying the design and practice elements of particular programs is essential. The existing in-home program descriptions are vague on that point. Frankel (1988) recommends that "well-designed, controlled studies are necessary...variables such as child development, school performance, and subsequent abuse or neglect should be examined for clients in both groups...the impact of programs on individual and family functioning and their links to placement outcome are crucial questions whose answers may lead to more effective matching of particular interventions with appropriately selected families...The identification of client and program characteristics that are associated with multiple indices of both success and failure are also necessary steps" (p.152). He also recommends that "several organizational models should be developed and tested" (p.153).

This practicum suggests that an in-home family therapy program with the added component of family intervention is an effective short-term treatment method to help families experiencing difficulties to learn to interact more positively.

With further research, similar programs will, hopefully, be more readily available to the people who would benefit from such a service.

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APPENDIX A

REFERRAL FORM

IN HOME FAMILY INTERVENTION PROGRAM

REFERRAL FORM

FAMILY NAME: _____

ADDRESS: _____

IDENTIFYING INFORMATION:

NAME	RELATION	AGE	EDUCATION/EMPLOYMENT

PRESENTING PROBLEM AND REASON FOR REFERRAL: _____

BRIEF HISTORY OF PREVIOUS INVOLVEMENT: _____

NAME OF WORKER: _____

PHONE NUMBER: _____

APPENDIX B

PERMISSION TO VIDEO TAPE

PERMISSION FOR OBSERVATION AND VIDEO TAPING

As a result of receiving the services of Child and Family Services of Winnipeg South, I and my family understand:

1) That observation and/or audiotaping or videotaping of therapy sessions may be required for the purposes of aiding treatment and supervision of the therapist;

2) That information obtained from interviews, therapy sessions, or any questionnaires my be shared with clinical supervisors;

3) That all information, whether on paper or audio/videotape is kept under strict conditions of professional confidentiality;

4) That any tapes will be erased after they have been viewed for supervision purposes.

Read and agreed to:

Name of Client/s: Date:

_____ _____

Signature of Client/s:

_____ _____

_____ _____

_____ _____

Signature of Therapist:

_____

APPENDIX C

FAMILY ASSESSMENT MEASURE
GENERAL SCALE

Family Assessment Measure

GENERAL SCALE

Directions

On the following pages you will find 50 statements about your family as a whole. Please read each statement carefully and decide how well the statement describes your family. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE with the statement then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

Please do not write on this page.
Circle your response on the answer sheet.

1. We spend too much time arguing about what our problems are.
2. Family duties are fairly shared.
3. When I ask someone to explain what they mean, I get a straight answer.
4. When someone in our family is upset, we don't know if they are angry, sad, scared or what.
5. We are as well adjusted as any family could possibly be.
6. You don't get a chance to be an individual in our family.
7. When I ask why we have certain rules, I don't get a good answer.
8. We have the same views on what is right and wrong.
9. I don't see how any family could get along better than ours.
10. Some days we are more easily annoyed than on others.
11. When problems come up, we try different ways of solving them.
12. My family expects me to do more than my share.
13. We argue about who said what in our family.
14. We tell each other about things that bother us.
15. My family could be happier than it is.
16. We feel loved in our family.
17. When you do something wrong in our family, you don't know what to expect.
18. It's hard to tell what the rules are in our family.
19. I don't think any family could possibly be happier than mine.
20. Sometimes we are unfair to each other.
21. We never let things pile up until they are more than we can handle.
22. We agree about who should do what in our family.
23. I never know what's going on in our family.
24. I can let my family know what is bothering me.
25. We never get angry in our family.

Please do not write on this page.
Circle your response on the answer sheet.

26. My family tries to run my life.
27. If we do something wrong, we don't get a chance to explain.
28. We argue about how much freedom we should have to make our own decisions.
29. My family and I understand each other completely.
30. We sometimes hurt each others feelings.
31. When things aren't going well it takes too long to work them out.
32. We can't rely on family members to do their part.
33. We take the time to listen to each other.
34. When someone is upset, we don't find out until much later.
35. Sometimes we avoid each other.
36. We feel close to each other.
37. Punishments are fair in our family.
38. The rules in our family don't make sense.
39. Some things about my family don't entirely please me.
40. We never get upset with each other.
41. We deal with our problems even when they're serious.
42. One family member always tries to be the centre of attention.
43. My family lets me have my say, even if they disagree.
44. When our family gets upset, we take too long to get over it.
45. We always admit our mistakes without trying to hide anything.
46. We don't really trust each other.
47. We hardly ever do what is expected of us without being told.
48. We are free to say what we think in our family.
49. My family is not a perfect success.
50. We have never let down another family member in any way.

APPENDIX D

PROBLEM CHECKLIST

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Making sensible rules					
5. Being able to discuss what is right and wrong.					
6. Sharing of responsibilities					
7. Handling anger and frustration					
8. Dealing with matters concerning sex					
9. Proper use of alcohol, drugs					
10. Use of discipline					
11. Use of physical force					
12. The amount of independence you have in the family					
13. Making contact with friends, relatives, church, etc.					
14. Relationships between parents					
15. Relationships between children					
16. Relationships between parents and children					
17. Time family members spend together					
18. Situation at work or school					
19. Family finances					
20. Housing situation					
21. Overall satisfaction with my family					

Make the last rating for yourself:

22. Feeling good about myself					

APPENDIX E

CHILD BEHAVIOR CHECKLIST
DIRECT OBSERVATION FORM

ID #

CHILD BEHAVIOR CHECKLIST — DIRECT OBSERVATION FORM (Rev. Ed.)

CHILD'S NAME

CHILD'S AGE	CHILD'S SEX ☐ Boy ☐ Girl	ETHNIC GROUP OR RACE	OBSERVER	OBSERVATION #
GRADE	TODAY'S DATE Mo. ____ Day ____ Yr. ____		SETTING 1. ☐ Class 2. ☐ Lunch 3. ☐ Recess 4. ☐ Other (specify):	1. ☐ Identified Child 2. ☐ Control Child 1 3. ☐ Control Child 2
TIME OF DAY	DATE OF BIRTH Mo. ____ Day ____ Yr. ____			

Revised Edition of the DOF. This edition of the DOF was constructed after the scoring profile for the DOF was completed in November, 1986. Because this edition has the same items as the first edition, both editions can be scored in the same way. However, this edition includes more detailed instructions, clarification of some item wording, and designation of items as Internalizing and Externalizing (I and E), based on factor-analytic findings. Hand-scored forms are available for computing, averaging, and comparing on-task scores, Internalizing, Externalizing, and total problem scores for the identified child and control children. Because the computation, averaging, and comparison of scores for the 6 narrow-band scales is laborious, we have not constructed hand-scoring forms for them, but they are included in our computer-scoring program for the DOF, which can be ordered from T.M. Achenbach, Ctr. for Children, Youth, & Families, 1 South Prospect St., Burlington, VT 05401.

General Instructions. The DOF is designed for use by an experienced observer who observes a child for 10-minute periods in a classroom or other group setting. During the observational period, write a narrative description of the child's behavior on page 3, noting the occurrence, duration, and intensity of specific problems. Include events that may affect the child's behavior. If a child is teased or hit by another child, for example, include this in the narrative as part of the basis for scoring the problem list.

At the end of each minute, note the child's on-task behavior for 5 seconds. If the child's behavior is on-task during the 5-second interval (e.g., behaving appropriately, following directions, working at desk, not annoying others), check the appropriate box on page 3. At the end of the 10-minute period, sum the on-task scores and score items 1-97 on pages 2 and 3. To obtain a representative sample of a child's behavior, make 10-minute observations on 3 to 6 separate occasions, such as mornings and afternoons of different days. Average the ratings across occasions as instructed on the DOF hand-scoring form or computer-scored profile.

Comparison with Control Children. To compare the identified child with others in the same setting, it is recommended that 1 control child of the same sex be observed for 10 minutes before the identified child and a second control child of the same sex be observed for 10 minutes after the identified child. The scores of the control children can then be averaged for comparison with the scores of the identified child according to instructions for the DOF hand-scoring form or computer-scored profile.

Scoring the Problems. For each problem observed, score only the item that most specifically describes the problem behavior, using the 0-1-2-3 scale specified on page 2. The score of 1 is to be used when the observer is uncertain whether a particular behavior occurred, as well as for definite but very slight occurrences. If the child displays problems that may seem related to each other but can be described by different items listed on pages 2-3, the item corresponding to each of the observed problems should be scored as present.

Because the DOF is intended to cover a wide range of possible problems and all ratings involve subjective judgment by the rater, the scoring scales and instructions cannot guarantee perfect precision or reliability. Furthermore, precise standardization is limited by the variety of possible observation conditions. The DOF is therefore designed to be informative under a wide range of conditions, but may not necessarily provide the precision expected from uniformly trained expert observers recording a more limited range of behavior under highly controlled conditions. (Guidelines for particular items are specified on page 4.)

For each item that describes the child's behavior **during the observational period**, circle the
0 if the item was not observed
1 if there was a very slight or ambiguous occurrence
2 if there was a definite occurrence with mild to moderate intensity **and** less than three minutes duration
3 if there was a definite occurrence with severe intensity **or** greater than three minutes duration

I = item scored on Internalizing scale
E = item scored on Externalizing scale

For each problem observed, score only the item that most specifically describes the behavior. Circle a score for every item.

I	0	1	2	3	1. Acts too young for age
I	0	1	2	3	2. Makes odd noises
E	0	1	2	3	3. Argues
	0	1	2	3	4. Behaves like opposite sex
E	0	1	2	3	5. Defiant or talks back to staff
E	0	1	2	3	6. Bragging, boasting
I	0	1	2	3	7. Doesn't concentrate or doesn't pay attention for long
I,E	0	1	2	3	8. Can't get mind off certain thoughts; obsessions (specify): _____
	0	1	2	3	9. Doesn't sit still, restless, or hyperactive
E	0	1	2	3	10. Clings to adults or too dependent
I	0	1	2	3	11. Confused or seems to be in a fog
	0	1	2	3	12. Cries
	0	1	2	3	13. Fidgets, including with objects
E	0	1	2	3	14. Cruelty, bullying, or meanness
I	0	1	2	3	15. Daydreams or gets lost in thoughts
	0	1	2	3	16. Deliberately harms self
E	0	1	2	3	17. Tries to get attention of staff
	0	1	2	3	18. Destroys own things
	0	1	2	3	19. Destroys property belonging to others
E	0	1	2	3	20. Disobedient
E	0	1	2	3	21. Disturbs other children
E	0	1	2	3	22. Doesn't seem to feel guilty after misbehaving
	0	1	2	3	23. Shows jealousy
	0	1	2	3	24. Eats, drinks, chews, or mouths things that are not food, excluding tobacco and junk foods (specify): _____
	0	1	2	3	25. Shows fear of specific situations or stimuli (specify): _____
	0	1	2	3	26. Says no one likes him/her
	0	1	2	3	27. Says others are out to get him/her
I,E	0	1	2	3	28. Expresses feelings of worthlessness or inferiority
	0	1	2	3	29. Gets hurt, accident prone
	0	1	2	3	30. Gets in physical fights
I,E	0	1	2	3	31. Gets teased
	0	1	2	3	32. Hears things that aren't there (specify): _____
I	0	1	2	3	33. Impulsive or acts without thinking, including calling out in class
	0	1	2	3	34. Physically isolates self from others
E	0	1	2	3	35. Lying or cheating
	0	1	2	3	36. Bites fingernails
I	0	1	2	3	37. Nervous, highstrung, or tense
I	0	1	2	3	38. Nervous movements or twitching (specify): _____
	0	1	2	3	39. Overconforms to rules
I	0	1	2	3	40. Too fearful or anxious

Total _____ Internalizing _____ Externalizing _____

E	0	1	2	3	41. Physically attacks people
	0	1	2	3	42. Picks nose, skin, or other parts of body (specify): _____
	0	1	2	3	43. Falls asleep
I	0	1	2	3	44. Apathetic, unmotivated, or won't try
	0	1	2	3	45. Refuses to talk
E	0	1	2	3	46. Disrupts group activities
	0	1	2	3	47. Screams
	0	1	2	3	48. Secretive, keeps things to self, including refusal to show things to teacher
	0	1	2	3	49. Sees things that aren't there (specify): _____
I	0	1	2	3	50. Self-conscious or easily embarrassed
	0	1	2	3	51. Sexual activity (specify): _____
E	0	1	2	3	52. Shows off or clowns
I	0	1	2	3	53. Shy or timid behavior
E	0	1	2	3	54. Explosive & unpredictable behavior (score temper on #71)
E	0	1	2	3	55. Demands must be met immediately, easily frustrated
	0	1	2	3	56. Easily distracted
I	0	1	2	3	57. Stares blankly
	0	1	2	3	58. Acts like feelings are hurt when criticized
	0	1	2	3	59. Steals
	0	1	2	3	60. Stores up things he/she doesn't need, except hobby items such as marbles (specify): _____
I	0	1	2	3	61. Strange behavior (specify): _____
	0	1	2	3	62. Strange ideas (specify): _____
I,E	0	1	2	3	63. Stubborn, sullen, or irritable
	0	1	2	3	64. Sudden changes in mood or feelings
	0	1	2	3	65. Sulks
	0	1	2	3	66. Suspicious
E	0	1	2	3	67. Swearing or obscene language
	0	1	2	3	68. Talks about killing self
	0	1	2	3	69. Talks too much
E	0	1	2	3	70. Teases
	0	1	2	3	71. Temper tantrums or hot temper
	0	1	2	3	72. Verbal expressions of preoccupation with sex
E	0	1	2	3	73. Threatens people
	0	1	2	3	74. Too concerned with neatness or cleanliness
I	0	1	2	3	75. Underactive, slow moving, lacks energy, or yawns
I	0	1	2	3	76. Unhappy, sad, or depressed
E	0	1	2	3	77. Unusually loud

Total _____ Internalizing _____ Externalizing _____

	0	1	2	3	78. Overly anxious to please
E	0	1	2	3	79. Whining tone of voice
I	0	1	2	3	80. Withdrawn, doesn't get involved with others
	0	1	2	3	81. Worrying
	0	1	2	3	82. Sucks thumb, hand, or arm
I	0	1	2	3	83. Fails to express self clearly, including speech defects
E	0	1	2	3	84. Impatient
I,E	0	1	2	3	85. Tattles
	0	1	2	3	86. Compulsions, repeats behavior over & over (specify): _____
	0	1	2	3	87. Easily led by peers
	0	1	2	3	88. Clumsy, poor motor control
I,E	0	1	2	3	89. Doesn't get along with peers

Total _____ **Internalizing** _____ **Externalizing** _____

	0	1	2	3	90. Runs out of class (or similar setting)
I	0	1	2	3	91. Behaves irresponsibly (specify): _____
E	0	1	2	3	92. Bossy
	0	1	2	3	93. Plays with younger children
E	0	1	2	3	94. Complains
I	0	1	2	3	95. Afraid to make mistakes
	0	1	2	3	96. Acts like poor loser
					97. Other problems (specify):
	0	1	2	3	_____
	0	1	2	3	_____
	0	1	2	3	_____

Total _____ **Internalizing** _____ **Externalizing** _____

Sum: Total Problem Score _____ Int _____ Ext _____

Boxes 1-10 represent 10 5-sec. intervals beginning at the end of each min. of observation. If child is **not on task during the 5-sec. interval, check the left box; If s/he is on task, check the right box.** Sum on-task checks to obtain on-task score ranging from 0-10. Use space below for narrative description.

1	NOT OT	ON TASK
2	NOT OT	ON TASK
3	NOT OT	ON TASK
4	NOT OT	ON TASK
5	NOT OT	ON TASK
6	NOT OT	ON TASK
7	NOT OT	ON TASK
8	NOT OT	ON TASK
9	NOT OT	ON TASK
10	NOT OT	ON TASK

SUM ON TASK _____

APPENDIX F

FAMILY INTERVENTION HOME VISIT REPORT

FAMILY INTERVENTION WORKER'S HOME VISIT REPORT

DATE: _____ TIME OF VISIT _____ TO _____

FAMILY NAME: _____

FAMILY MEMBERS PRESENT: _____

_____

_____

GOALS OF VISIT: _____

_____

_____

_____

_____

_____

GOALS ACCOMPLISHED: _____

_____

_____

_____

_____

_____

VISIT SUMMARY: _____

_____

_____

_____

_____

_____

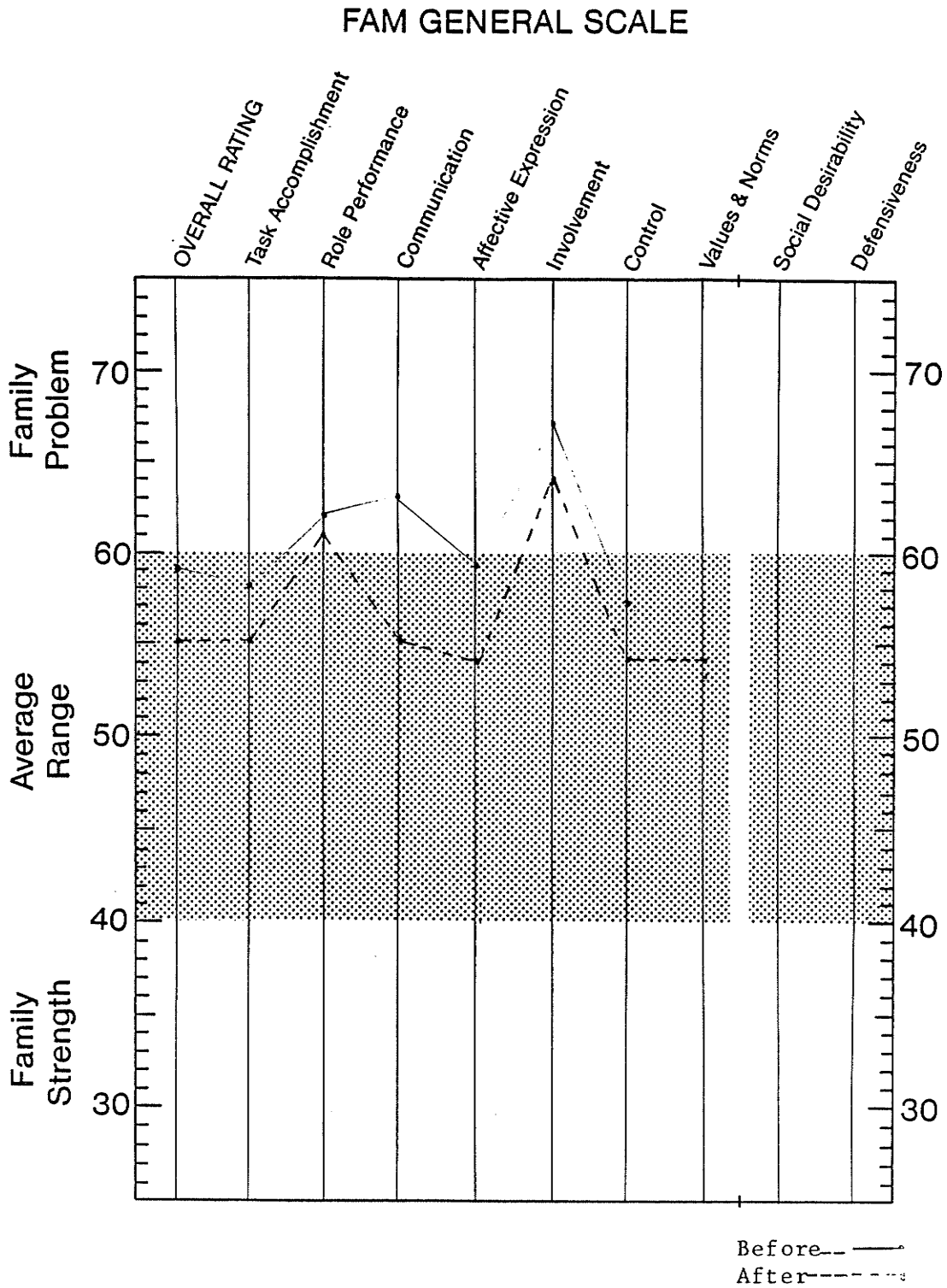
_____

_____

NAME: _____ DATE: _____

APPENDIX G

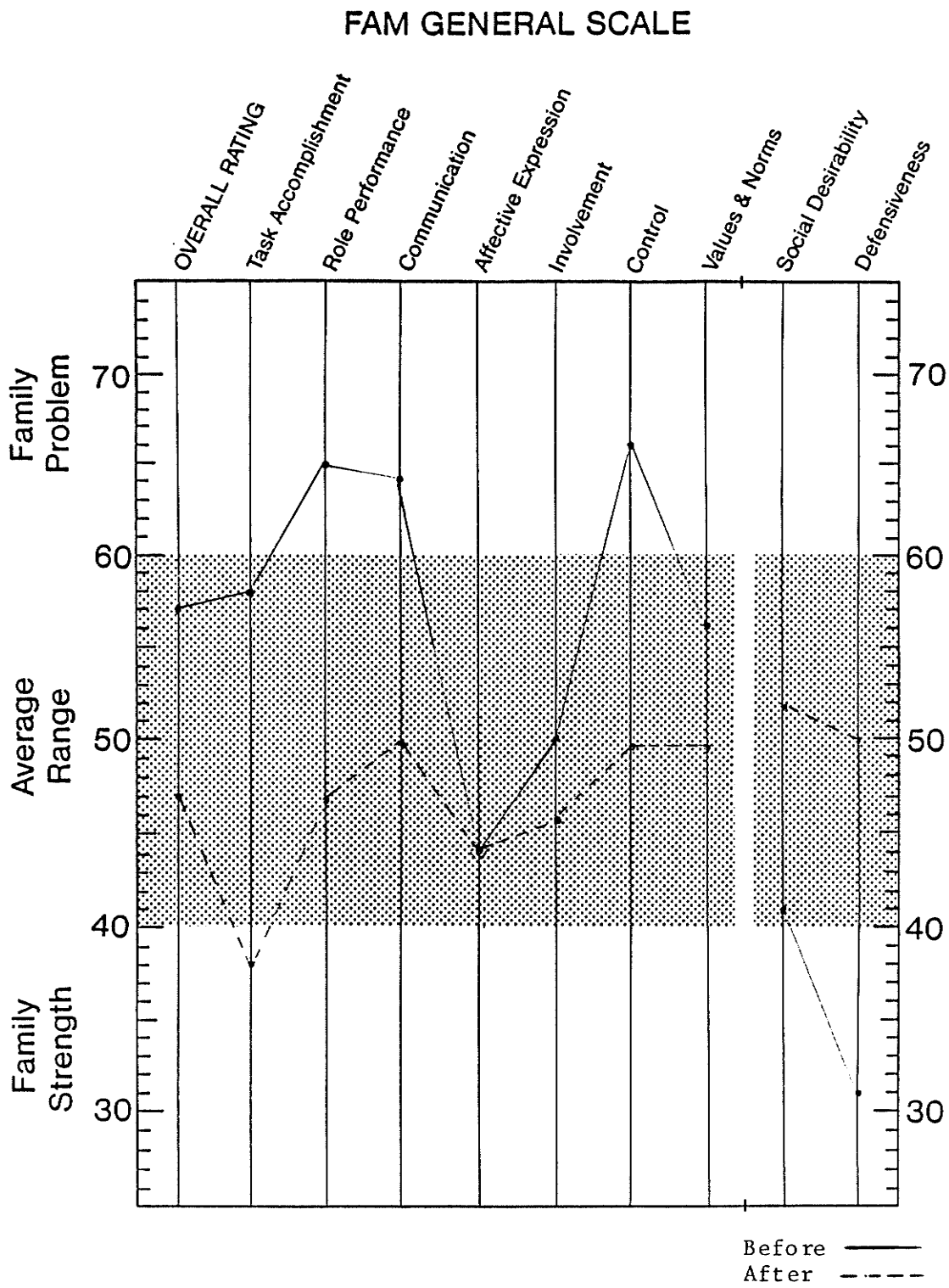
AVERAGE OF PARENTS' OF ALL FAMILIES FAM SCORES


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

APPENDIX H

BARB R.

H1--FAM
H2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)		✓			X
2. Sharing feelings like anger, sadness, hurt, etc.		✓			X
3. Sharing problems with the family			✓		X
4. Making sensible rules			✓	X	
5. Being able to discuss what is right and wrong.				✓	X
6. Sharing of responsibilities				✓ X	
7. Handling anger and frustration			✓		
8. Dealing with matters concerning sex		✓			✓
9. Proper use of alcohol, drugs				✓	X
10. Use of discipline		✓			✓
11. Use of physical force			✓		X
12. The amount of independence you have in the family			✓		X
13. Making contact with friends, relatives, church, etc.				✓ X	
14. Relationships between parents				✓ X	
15. Relationships between children			✓	X	
16. Relationships between parents and children			✓	X	
17. Time family members spend together			✓		X
18. Situation at work or school		✓		X	
19. Family finances		✓	X		
20. Housing situation		✓	X		
21. Overall satisfaction with my family			✓		X

Make the last rating for yourself:

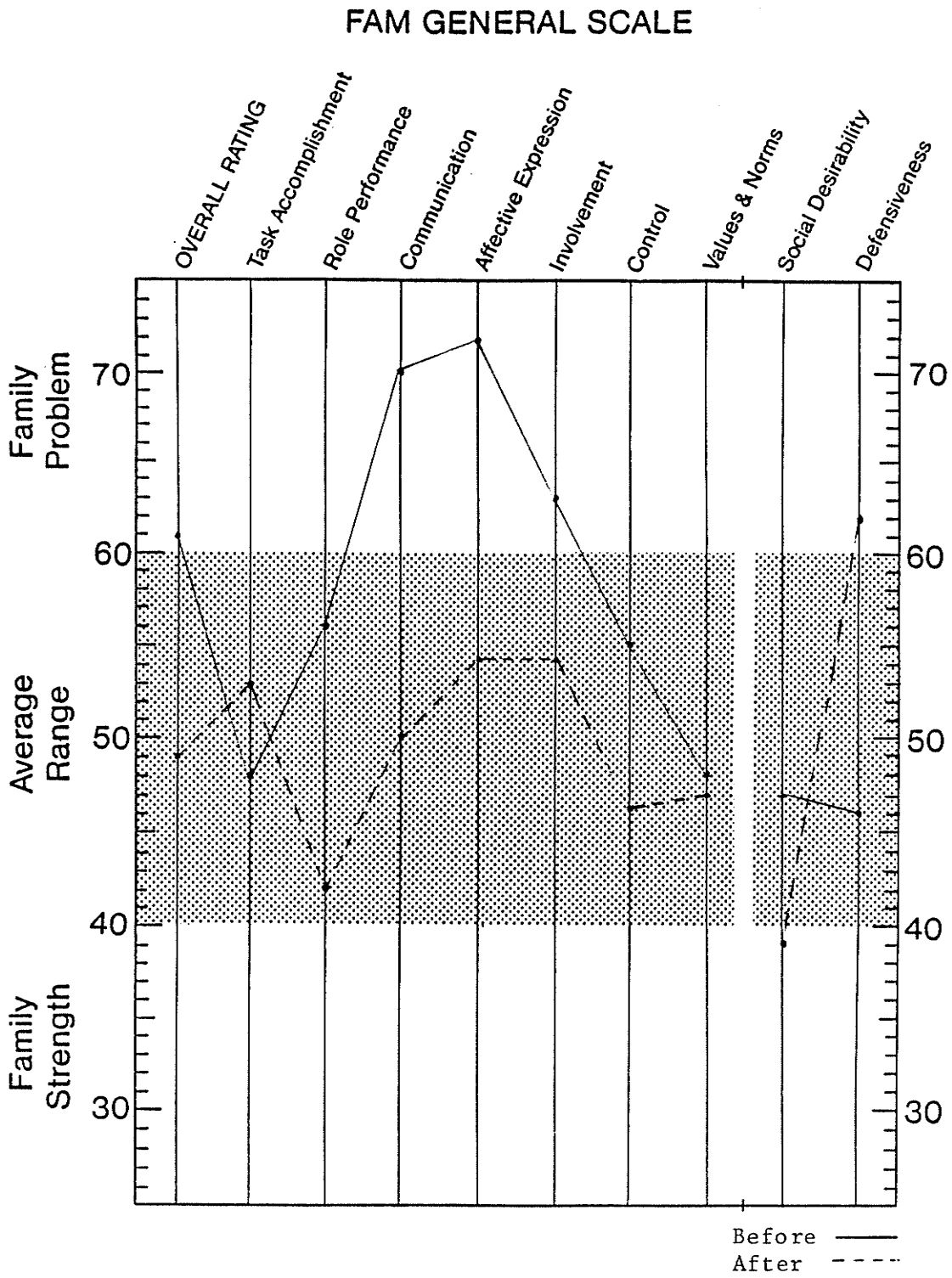
22. Feeling good about myself		✓		X	

Before ✓
After X

APPENDIX J

MONA W.

J1--FAM
J2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				✓ X	
2. Sharing feelings like anger, sadness, hurt, etc.		✓		X	
3. Sharing problems with the family		✓	X		
4. Making sensible rules			✓	X	
5. Being able to discuss what is right and wrong.		✓		X	
6. Sharing of responsibilities			✓	X	
7. Handling anger and frustration		✓		X	
8. Dealing with matters concerning sex		✓		X	
9. Proper use of alcohol, drugs				✓ X	
10. Use of discipline		✓		X	
11. Use of physical force			✓	X	
12. The amount of independence you have in the family				✓ X	
13. Making contact with friends, relatives, church, etc.				✓ X	
14. Relationships between parents				✓ X	
15. Relationships between children				✓ X	
16. Relationships between parents and children				✓ X	
17. Time family members spend together		✓		X	
18. Situation at work or school			X	✓	
19. Family finances				✓ X	
20. Housing situation				✓ X	
21. Overall satisfaction with my family			✓	X	

Make the last rating for yourself:

22. Feeling good about myself				✓ X	

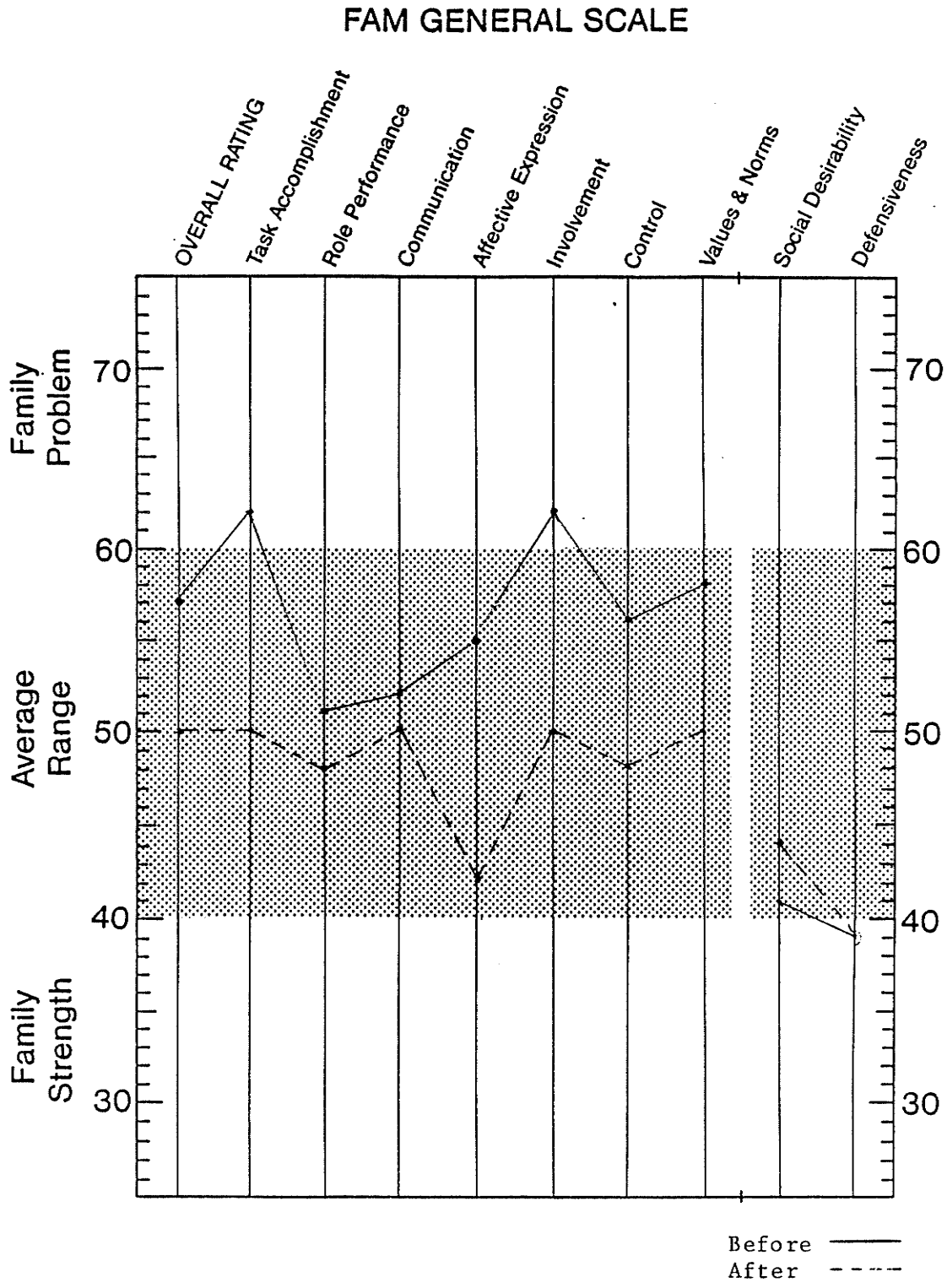
Before ✓
After X

APPENDIX K

VANNA W.

K1--FAM

K2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			✓		✓
2. Sharing feelings like anger, sadness, hurt, etc.			✓ X		
3. Sharing problems with the family		✓			
4. Making sensible rules			✓	X	
5. Being able to discuss what is right and wrong.				✓ X	
6. Sharing of responsibilities				✓ X	
7. Handling anger and frustration			✓ X		
8. Dealing with matters concerning sex				✓ X	
9. Proper use of alcohol, drugs				X	✓
10. Use of discipline			✓	X	
11. Use of physical force				X	✓
12. The amount of independence you have in the family				✓ X	
13. Making contact with friends, relatives, church, etc.			✓	X	
14. Relationships between parents				✓ X	
15. Relationships between children			✓ X		
16. Relationships between parents and children				✓ X	
17. Time family members spend together			✓	X	
18. Situation at work or school				✓ X	
19. Family finances				X	✓
20. Housing situation				✓ X	
21. Overall satisfaction with my family				✓ X	

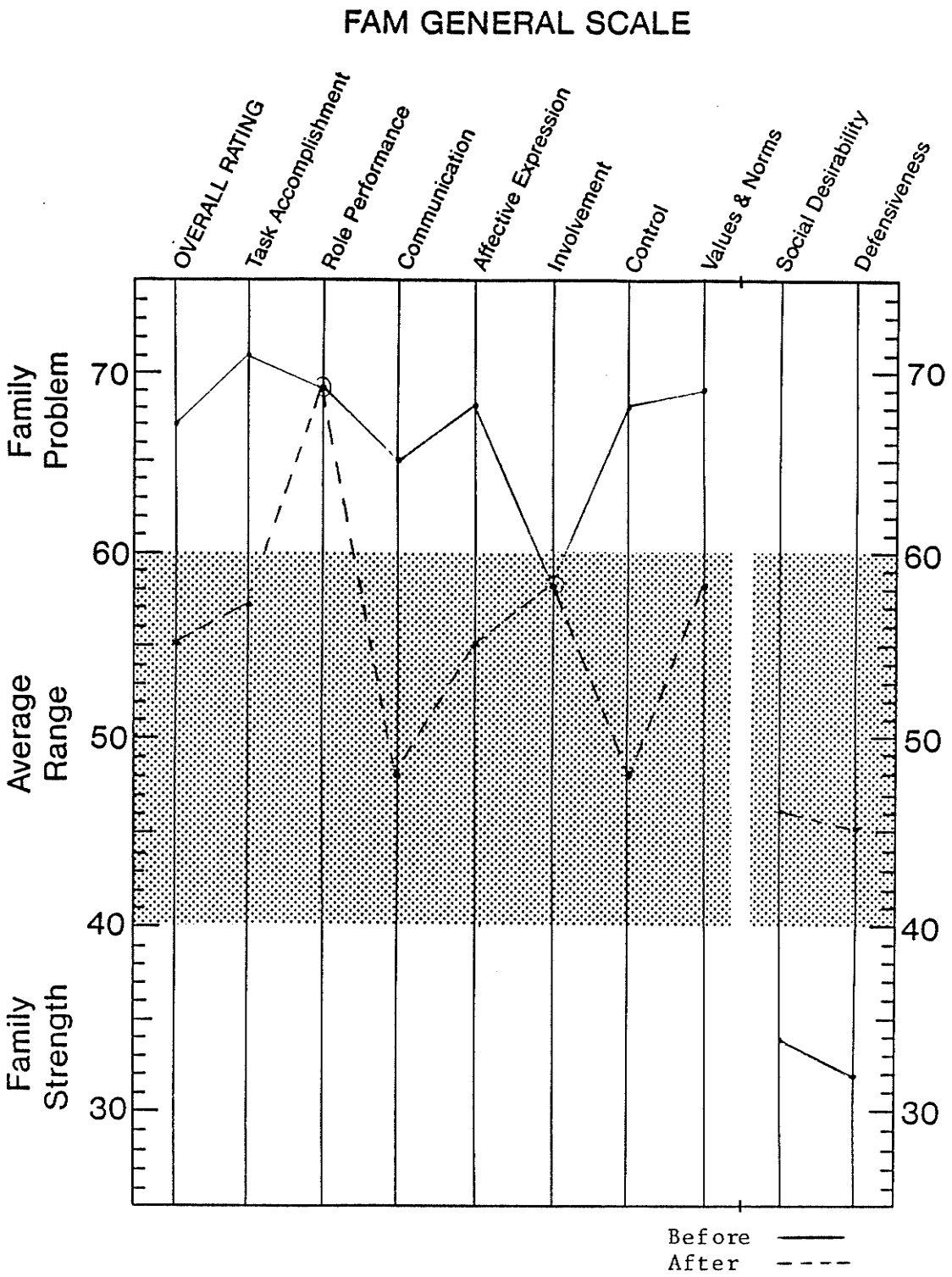
Make the last rating for yourself:

22. Feeling good about myself				X	✓

Before ✓
After X

APPENDIX L

PAUL W.
L1--FAM
L2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			✓	X	
2. Sharing feelings like anger, sadness, hurt, etc.				✓	✓
3. Sharing problems with the family		✓		X	
4. Making sensible rules	✓				X
5. Being able to discuss what is right and wrong.				✓	X
6. Sharing of responsibilities			X		✓
7. Handling anger and frustration			✓ X		
8. Dealing with matters concerning sex					✓ X
9. Proper use of alcohol, drugs					✓ X
10. Use of discipline				✓	X
11. Use of physical force					✓ X
12. The amount of independence you have in the family			✓	X	
13. Making contact with friends, relatives, church, etc.		✓			X
14. Relationships between parents					✓ X
15. Relationships between children			✓		X
16. Relationships between parents and children				✓	X
17. Time family members spend together			✓	X	
18. Situation at work or school				X	✓ X
19. Family finances			✓		
20. Housing situation				✓ X	
21. Overall satisfaction with my family			✓	X	

Make the last rating for yourself:

22. Feeling good about myself				✓	X

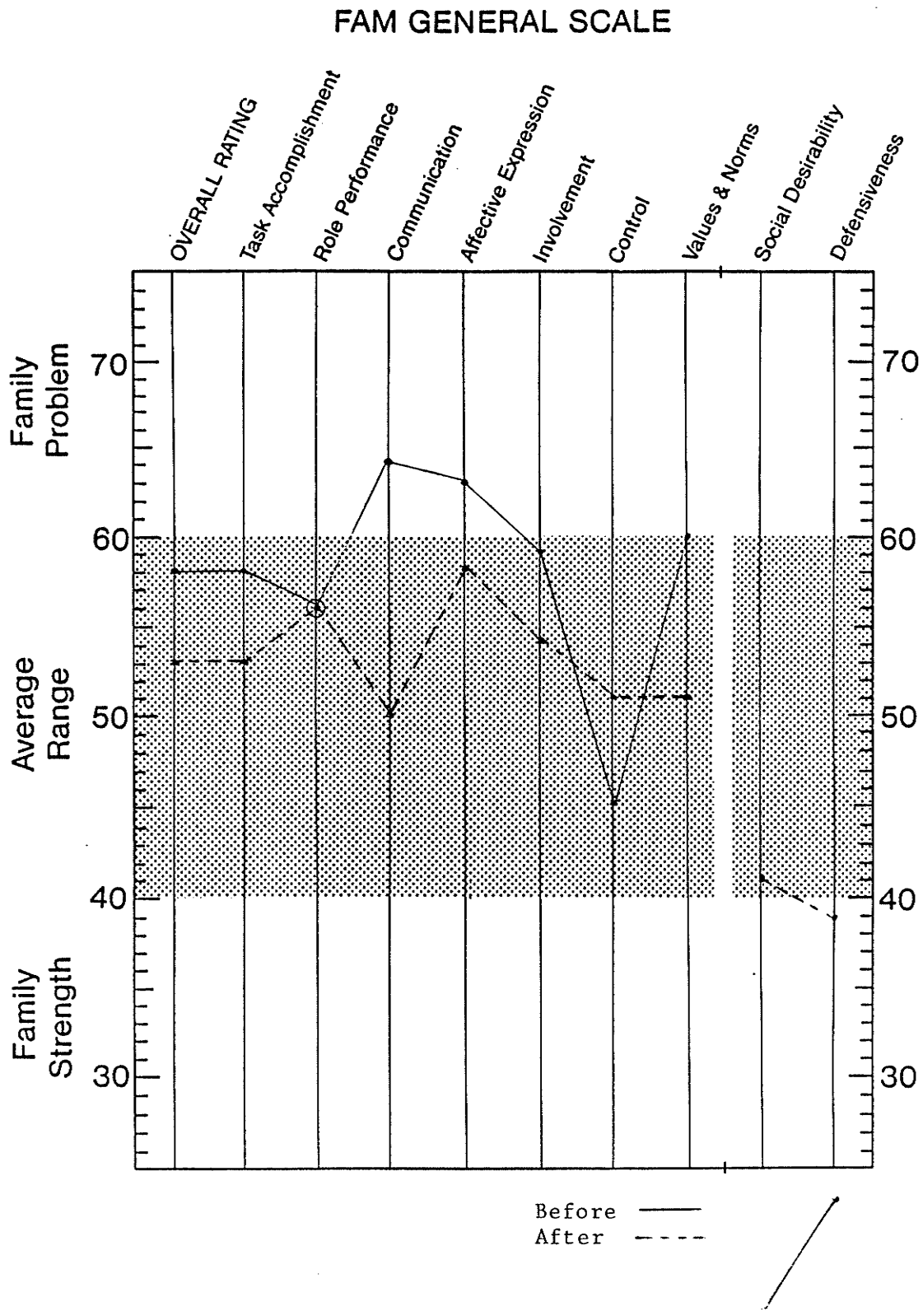
Before ✓
After X

APPENDIX M

BOB W.

M1--FAM

M2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)		✓	X		
2. Sharing feelings like anger, sadness, hurt, etc.		✓	X		
3. Sharing problems with the family		✓	X		
4. Making sensible rules			X	✓	
5. Being able to discuss what is right and wrong.		✓	X		
6. Sharing of responsibilities		✓	X		
7. Handling anger and frustration		✓	X		
8. Dealing with matters concerning sex	✓			X	
9. Proper use of alcohol, drugs				✓ X	
10. Use of discipline			✓ X		
11. Use of physical force				✓ X	
12. The amount of independence you have in the family		✓	X		
13. Making contact with friends, relatives, church, etc.		✓		X	
14. Relationships between parents				✓	
15. Relationships between children		✓	X		
16. Relationships between parents and children		✓	X		
17. Time family members spend together			✓ X		
18. Situation at work or school			✓ X		
19. Family finances		✓	X		
20. Housing situation		✓ X			

21. Overall satisfaction with my family		✓	X		

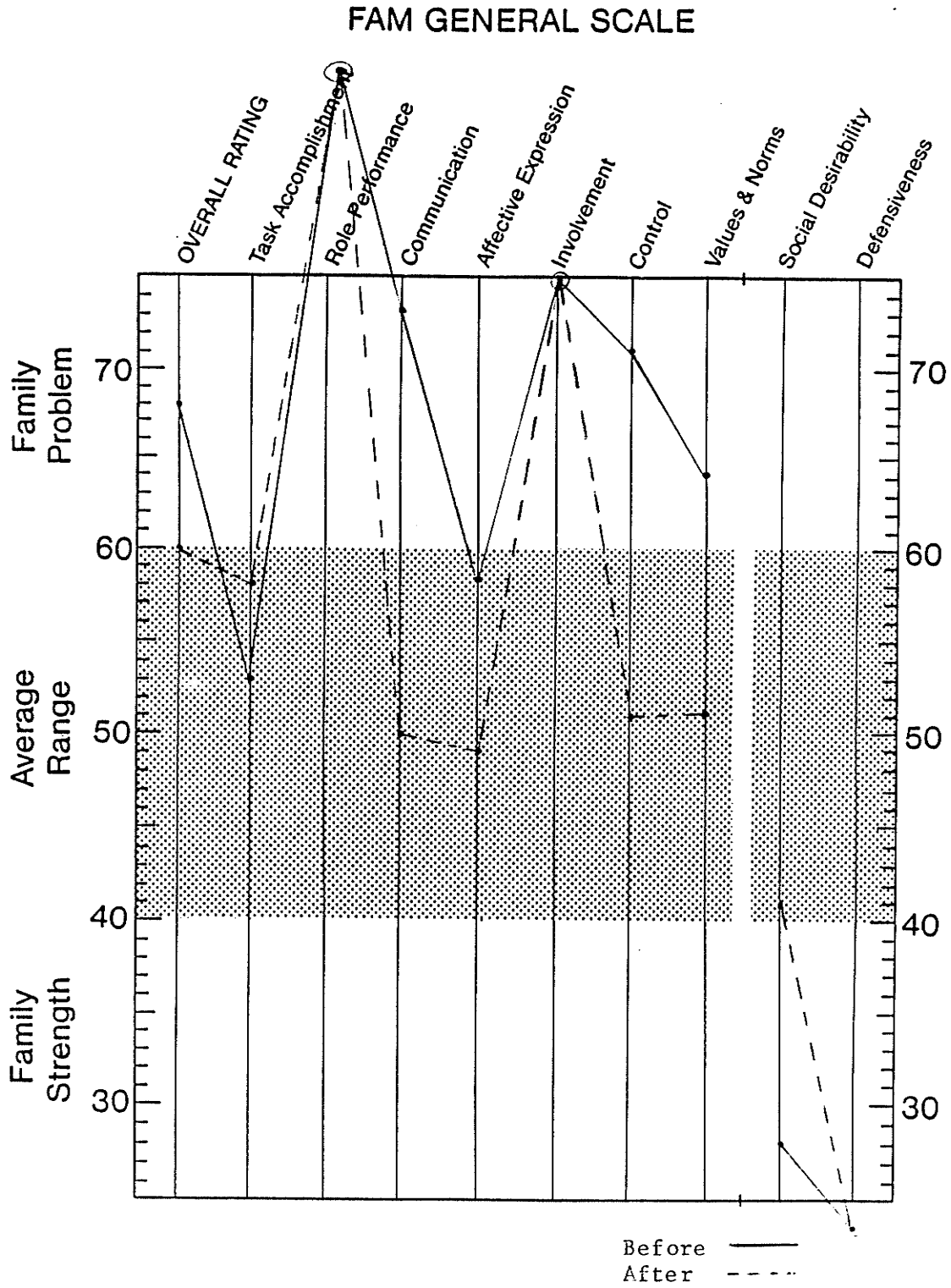
Make the last rating for yourself:

22. Feeling good about myself				X	✓

Before ✓
After X

APPENDIX N

DARLENE F.
N1--FAM
N2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
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50
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30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			✓	X	
2. Sharing feelings like anger, sadness, hurt, etc.		✓		X	
3. Sharing problems with the family		✓		X	
4. Making sensible rules			✓	X	
5. Being able to discuss what is right and wrong.	✓			X	
6. Sharing of responsibilities	✓	X			
7. Handling anger and frustration	✓		X		
8. Dealing with matters concerning sex		X	✓		
9. Proper use of alcohol, drugs					✓ X
10. Use of discipline		✓ X			
11. Use of physical force	✓			X	
12. The amount of independence you have in the family		✓		X	
13. Making contact with friends, relatives, church, etc.		✓		X	
14. Relationships between parents	✓		X		
15. Relationships between children			✓ X		
16. Relationships between parents and children		✓	X		
17. Time family members spend together		✓		X	
18. Situation at work or school		✓	X		
19. Family finances	✓		X		
20. Housing situation			✓ X		
21. Overall satisfaction with my family			✓ X		

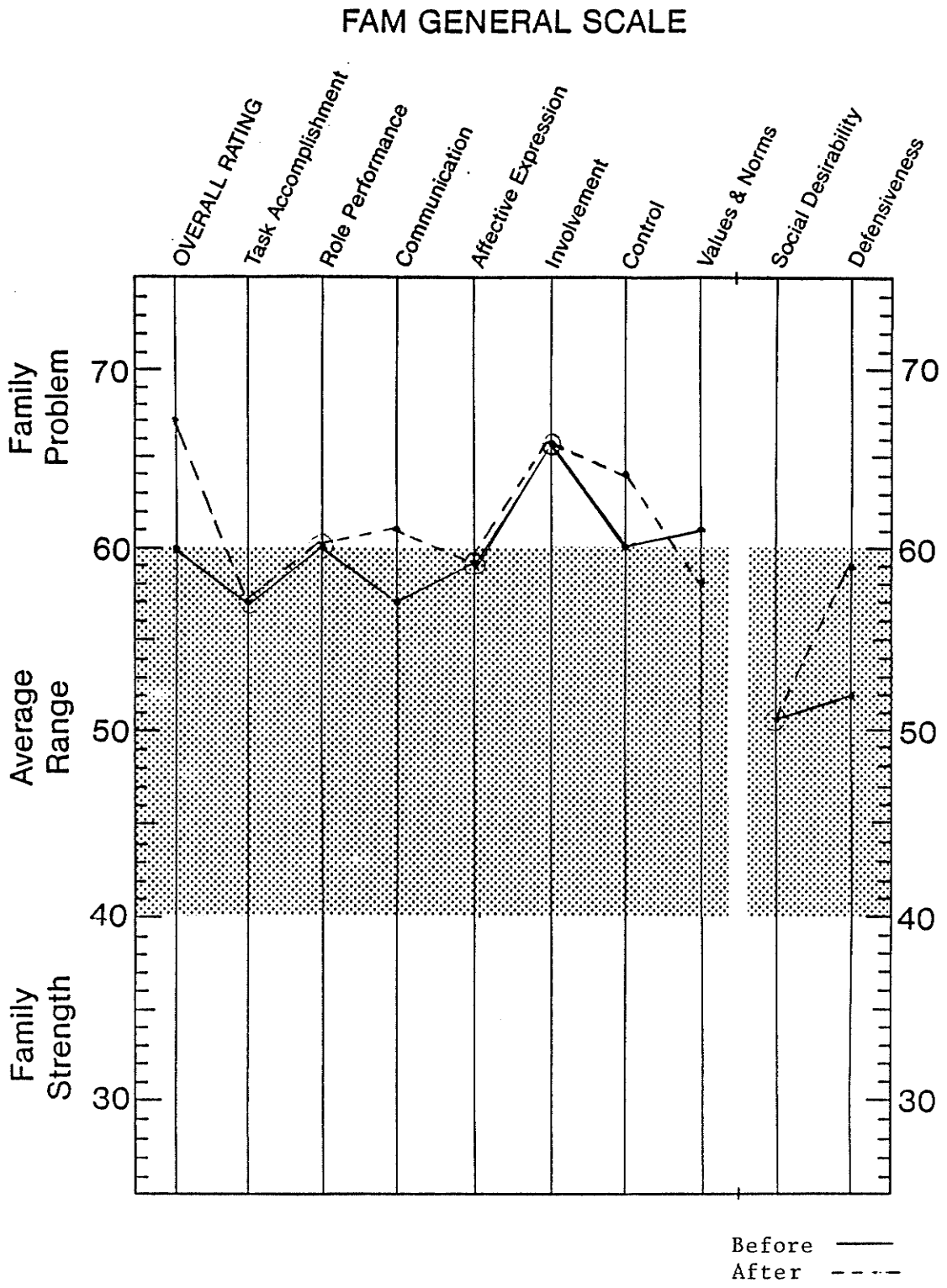
Make the last rating for yourself:

22. Feeling good about myself		✓		X	

Before ✓
After X

APPENDIX O

SAM F.
O1--FAM
02--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			✓		X
2. Sharing feelings like anger, sadness, hurt, etc.			✓		X
3. Sharing problems with the family			✓		X
4. Making sensible rules				✓	X
5. Being able to discuss what is right and wrong.			✓		X
6. Sharing of responsibilities			✓ X		
7. Handling anger and frustration			✓		X
8. Dealing with matters concerning sex			✓	X	
9. Proper use of alcohol, drugs	✓				X
10. Use of discipline			✓		X
11. Use of physical force				✓	X
12. The amount of independence you have in the family			✓		X
13. Making contact with friends, relatives, church, etc.			✓		X
14. Relationships between parents					✓ X
15. Relationships between children	✓				X
16. Relationships between parents and children			✓		X
17. Time family members spend together				✓	X
18. Situation at work or school			✓		X
19. Family finances		X	✓		
20. Housing situation				✓	X
21. Overall satisfaction with my family			✓		X

Make the last rating for yourself:

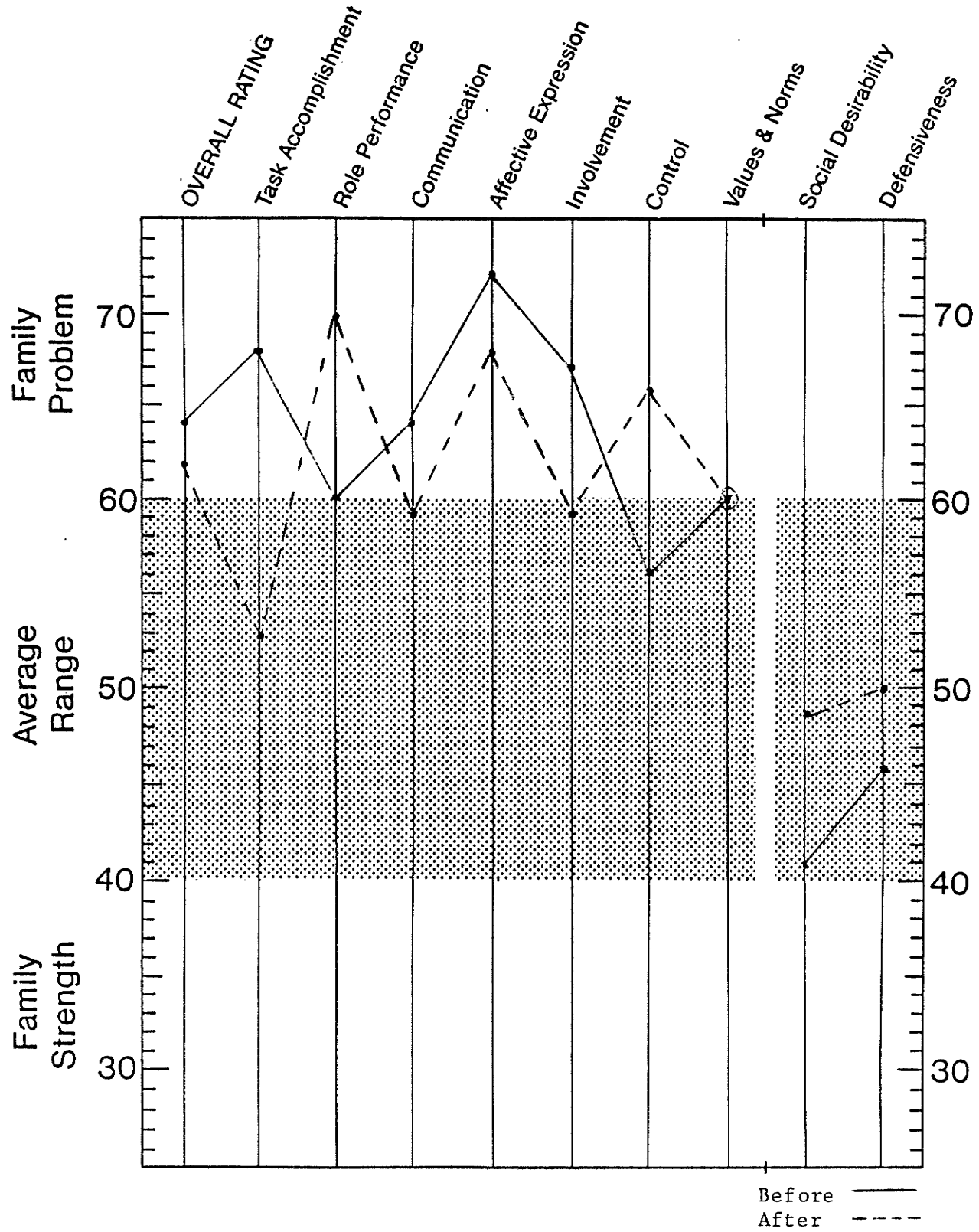
22. Feeling good about myself		✓			X

Before ✓
After X

APPENDIX P

DEB H.
P1--FAM
P2--PROBLEM CHECKLIST

FAM GENERAL SCALE



Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				✓ X	
2. Sharing feelings like anger, sadness, hurt, etc.			✓ X		
3. Sharing problems with the family			✓ X		
4. Making sensible rules				✓ X	
5. Being able to discuss what is right and wrong.				✓ X	
6. Sharing of responsibilities			✓ X		
7. Handling anger and frustration			✓	X	
8. Dealing with matters concerning sex				✓ X	
9. Proper use of alcohol, drugs				✓	X
10. Use of discipline				✓ X	
11. Use of physical force				✓ X	
12. The amount of independence you have in the family				✓ X	
13. Making contact with friends, relatives, church, etc.			✓	X	
14. Relationships between parents				✓	X
15. Relationships between children				✓ X	
16. Relationships between parents and children				✓	X
17. Time family members spend together			✓	X	
18. Situation at work or school			✓	X	
19. Family finances			✓ X		
20. Housing situation				✓ X	
21. Overall satisfaction with my family			✓		X

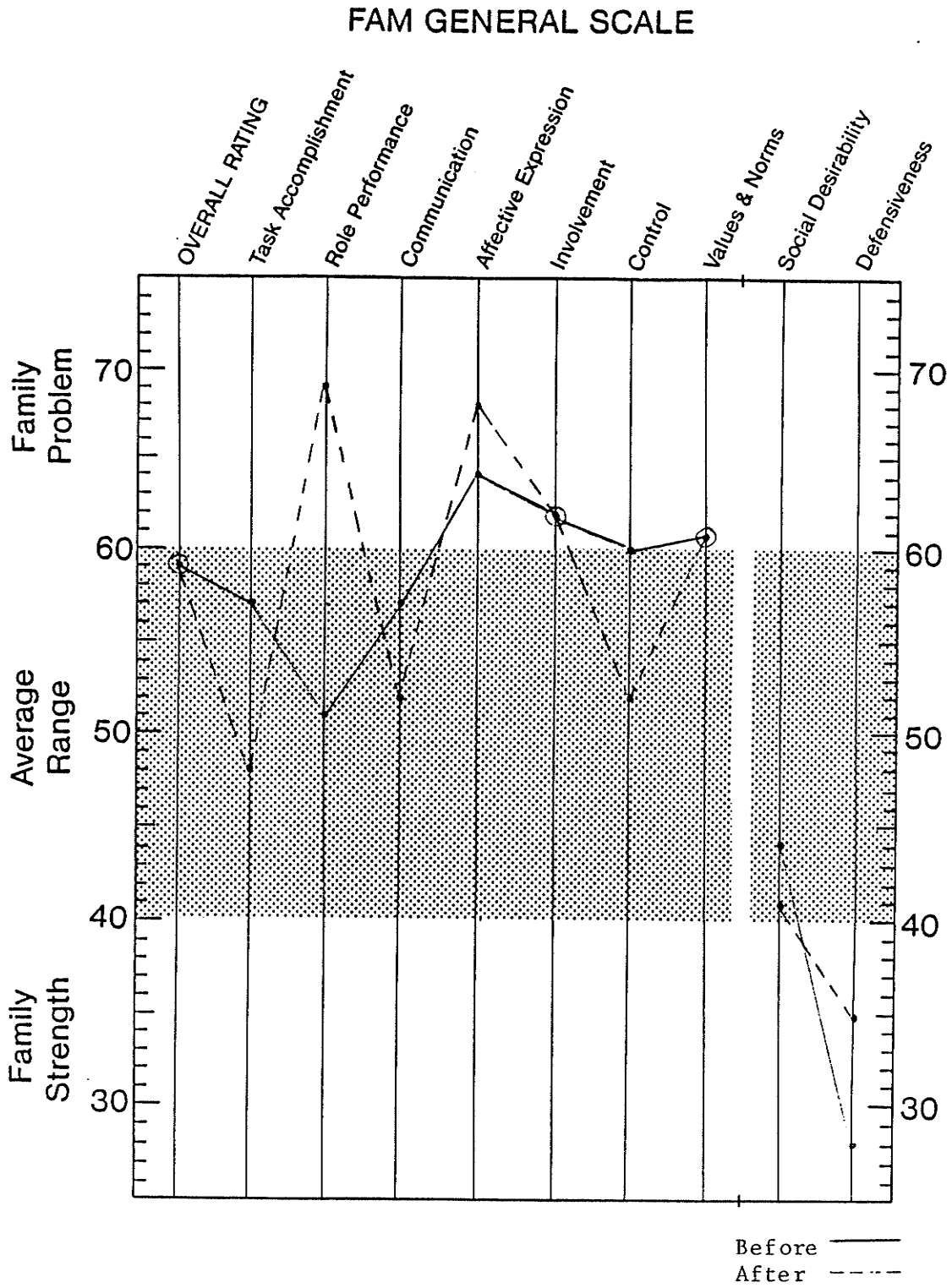
Make the last rating for yourself:

22. Feeling good about myself				✓ X	

Before ✓
After X

APPENDIX R

TARA H.
R1--FAM
R2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	✓
2. Sharing feelings like anger, sadness, hurt, etc.			✓	X	
3. Sharing problems with the family			✓	X	
4. Making sensible rules			✓	X	
5. Being able to discuss what is right and wrong.			✓	X	
6. Sharing of responsibilities			✓ X		
7. Handling anger and frustration			✓ X		
8. Dealing with matters concerning sex				✓ X	
9. Proper use of alcohol, drugs				✓ X	
10. Use of discipline			X	✓	
11. Use of physical force	X		✓		
12. The amount of independence you have in the family				✓ X	
13. Making contact with friends, relatives, church, etc.				✓ X	
14. Relationships between parents			✓	X	
15. Relationships between children			✓ X		
16. Relationships between parents and children			✓	X	
17. Time family members spend together				✓ X	
18. Situation at work or school			✓	X	
19. Family finances	X		✓		
20. Housing situation			✓ X		
21. Overall satisfaction with my family			✓	X	

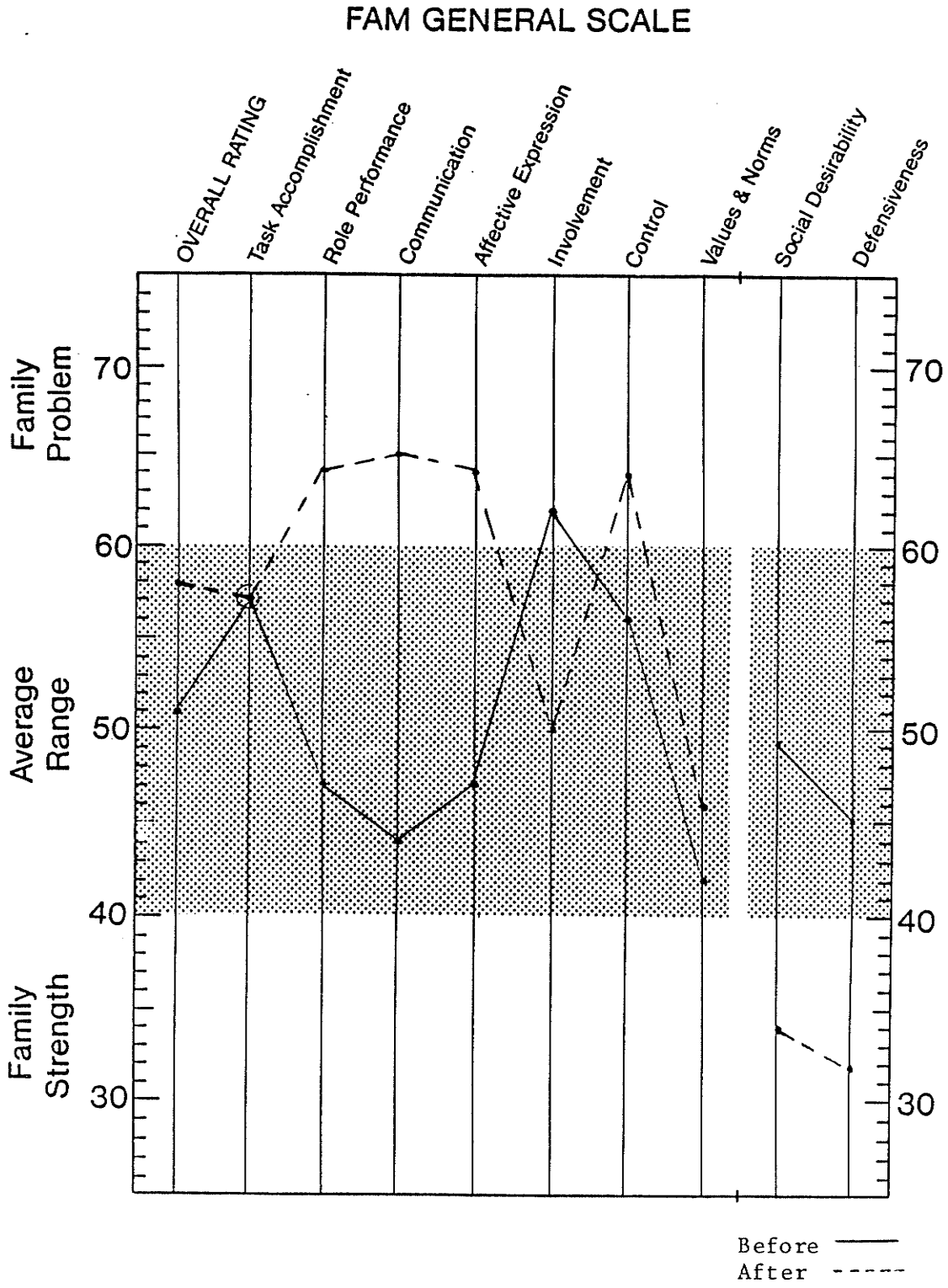
Make the last rating for yourself:

22. Feeling good about myself				✓	X

Before ✓
After X

APPENDIX S

KRISTIE H.
S1--FAM
S2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			X	✓	
2. Sharing feelings like anger, sadness, hurt, etc.			✓ X		
3. Sharing problems with the family			✓ X		
4. Making sensible rules			X		✓
5. Being able to discuss what is right and wrong.			✓ X		
6. Sharing of responsibilities			✓ X		
7. Handling anger and frustration	✓			X	
8. Dealing with matters concerning sex					✓ X
9. Proper use of alcohol, drugs	✓		X		
10. Use of discipline			✓ X		
11. Use of physical force			X	✓	
12. The amount of independence you have in the family		✓		X	
13. Making contact with friends, relatives, church, etc.			✓		X
14. Relationships between parents	✓ X				
15. Relationships between children			✓	X	
16. Relationships between parents and children			✓ X		
17. Time family members spend together		X	✓		
18. Situation at work or school			✓	X	
19. Family finances			X		✓
20. Housing situation		X	✓		
21. Overall satisfaction with my family			X		✓

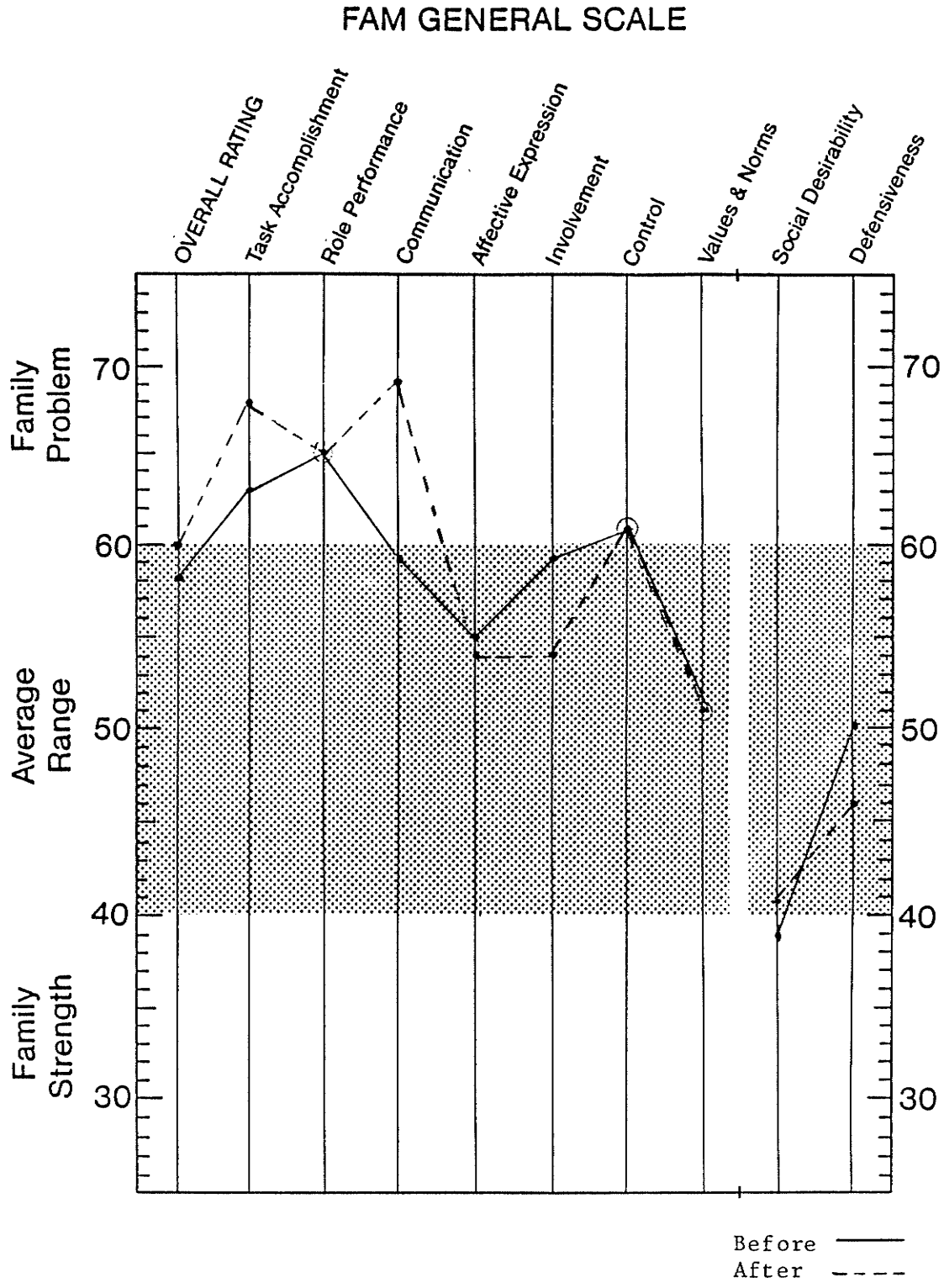
Make the last rating for yourself:

22. Feeling good about myself	✓				X

Before ✓
After X

APPENDIX T

STACY C.
T1--FAM
T2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	✓
2. Sharing feelings like anger, sadness, hurt, etc.	✓	X			
3. Sharing problems with the family		✓ X			
4. Making sensible rules		✓ X			
5. Being able to discuss what is right and wrong.		✓	X		
6. Sharing of responsibilities			✓ X		
7. Handling anger and frustration		X	✓		
8. Dealing with matters concerning sex				X	✓
9. Proper use of alcohol, drugs					✓ X
10. Use of discipline				✓ X	
11. Use of physical force				✓ X	
12. The amount of independence you have in the family				✓ X	
13. Making contact with friends, relatives, church, etc.			✓	X	
14. Relationships between parents		✓		X	
15. Relationships between children				✓ X	
16. Relationships between parents and children			✓	X	
17. Time family members spend together			✓ X		
18. Situation at work or school		✓	X		
19. Family finances		✓	X		
20. Housing situation		✓	X		
21. Overall satisfaction with my family			✓	X	

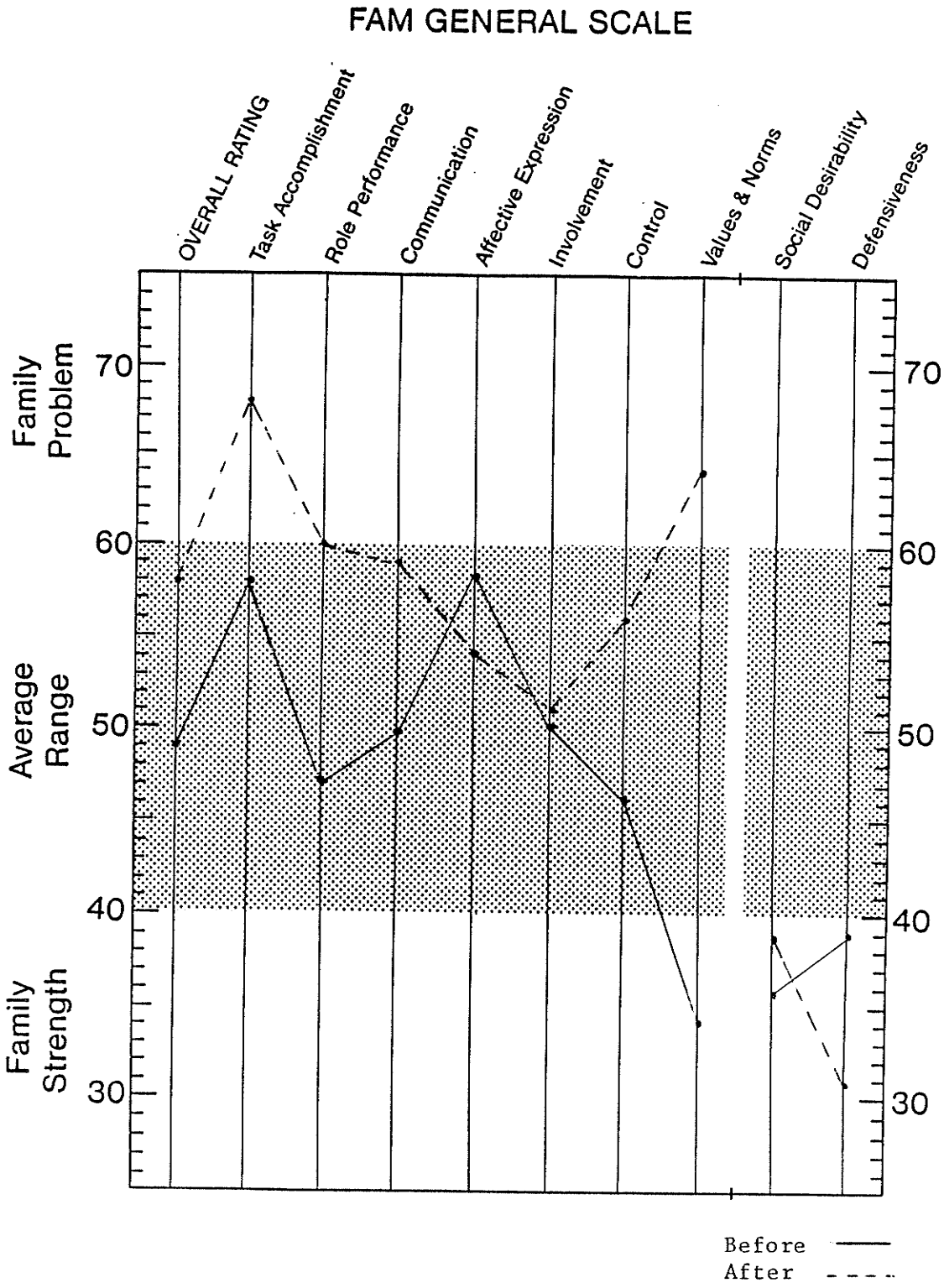
Make the last rating for yourself:

22. Feeling good about myself			✓	X	

Before ✓
After X

APPENDIX U

CHARLIE C.
U1--FAM
U2--PROBLEM CHECKLIST


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Before
After

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					✓ X
2. Sharing feelings like anger, sadness, hurt, etc.		X	✓		
3. Sharing problems with the family			✓ X		
4. Making sensible rules		X	✓		
5. Being able to discuss what is right and wrong.		✓	X		
6. Sharing of responsibilities			✓ X		
7. Handling anger and frustration		✓	X		
8. Dealing with matters concerning sex				X	✓
9. Proper use of alcohol, drugs					✓ X
10. Use of discipline				✓ X	
11. Use of physical force			✓	X	
12. The amount of independence you have in the family				✓ X	
13. Making contact with friends, relatives, church, etc.				✓ X	
14. Relationships between parents			✓ X		
15. Relationships between children				✓ X	
16. Relationships between parents and children			✓	X	
17. Time family members spend together		✓	X		
18. Situation at work or school				✓ X	
19. Family finances					✓ X
20. Housing situation			✓	X	
21. Overall satisfaction with my family				✓ X	

Make the last rating for yourself:

22. Feeling good about myself				✓ X	

Before ✓
After X

March 15, 1988

Thomas M. Achenbach
Child, Adolescent, Family and
Community Psychiatry
University of Vermont,
1 South Prospect Street
Burlington, Vermont
05401

Dear Thomas Achenbach;

I am a graduate student in social work at the University of Manitoba in Winnipeg, Manitoba, Canada. I am embarking upon my practicum in late April of this year. The Child Behavior Checklist has recently been suggested to me as a possible instrument to use with the families whom I will be working with during my practicum.

I am attempting to explore the efficacy of an in-home family treatment program with families involved with a child welfare agency here in Winnipeg. I hope to incorporate family therapy with a coordinated in-home family support component. As a part of that attempt, I have been looking for a reliable and valid measure for the observation of children's behaviour.

I am requesting permission to use and copies of the CBCL (both manual and instrument) in order to utilize it in my practicum. I realize that I am not giving you much notice, but I hope that any charges involved can be arranged COD.

Thank you for your attention to this matter.

Sincerely,

Adele McDougall, BSW

Winnipeg, Manitoba

You have our permission to use the CBCL in your study. I am enclosing an order form for your convenience in ordering. We do not ship COD but we will be happy to fill your order as soon as we receive it.

Jill Brown for T.M. Achenbach, PH.D.
Publications Distribution Manager

Alcoholism and Drug
Addiction Research Foundation
Fondation de la recherche sur la toxicomanie

Central Office
33 Russell Street
Toronto, Ontario
Canada M5S 2S1
(416) 595-6000

August 29, 1988

Adele McDougall

Winnipeg, Manitoba
R3E 2N7

Dear Ms. McDougall:

Thank you for your recent letter and description of your use of FAM-III in the pre- and post-assessment of families. The purpose of this letter is to give you formal permission to use FAM-III in your practicum research. You also have my permission to reproduce copies of the instrument as part of the final report from your practicum research.

Enclosed are 30 copies of the FAM graph. With all good wishes.

Sincerely,

Harvey A. Skinner, Ph.D.
Senior Scientist

HAS/rs

Encls.