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FAMILY PRESERVATION JOURNAL

A Publication of the *Family Preservation Institute*

Volume 2 Issue 1 1997

ARTICLES

**What's Working in Family-Based Services?--or,
What's Left to Believe in During A Time of Such Doubt?**

Roger Friedman

The Family Preservation Philosophy and Therapy With Lesbian Clients

Pamela De Santa

**Parenting Pioneers and Parenting Teams: Strengthening Extended
Family Ties in Family Support Programs**

Susan Whitelaw Downs

**Conceptual Bases of the Planning Process in Family
Preservation/Family Support State Plans**

June Lloyd

PLUS a review of current resources



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Provide five copies of the manuscripts. The title page only should list the author's name, affiliation, address, and telephone number. The author's name must not appear after the title page; only the title should appear on the

abstract and first page of the text. Include an abstract of about 100 words.

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Editorial

The Impact of Welfare Reform on Families

On the horizon a huge wave is building, about to crash down on the poorest most hard pressed families in our country. The impact of welfare reform on families and on those who serve them will be profound. The degree to which families and workers will be adversely affected is to date not fully understood. Yet as my son concluded, "...basically, if you are on welfare you had better win the lottery or learn to swim in the treacherous waters of poverty!" (C. Sallee, personal communication, November, 1996). We are also informed by looking back at the Elizabethan Poor Laws of 1601 where we find the origin of welfare reform. Orphanages, the responsibility of relatives, poorhouses and awarding relief work to the lowest private sector bidder, all introduced in the beginning of the welfare state, are key components of the current reform. The Personal Responsibility and Work Opportunity Act of 1996 washes away the entitlements and rights created during this country's greatest depression, leaving exposed the stark selfishness of the junk bond 1980's.

The impact of welfare reform will be largely borne by women and their children. If ever there is an illustration of the feminization of poverty, this is it. From teenage mothers being required to live with their parents, in what we know are often abusive homes, to wives who are forced to remain in unhealthy marriages, this policy will greatly affect women. We know mothers will eat less and less well in order to provide for their children. Women and their children in increasing numbers will be forced to choose between living in abusive situations and inadequate living arrangements. Families will be forced to live in over-crowded situations or on the street.

Poor children, who already have so little of the wealth of this country, will in even greater numbers be shipped off to low cost day care or to relatives who may or may not wish to care for them. The one thing that poor children may have in the world, love and bonding with their mothers (and hopefully fathers), will be greatly reduced as their parents are forced out of the home and into menial, low paying jobs or "make work" community services.

For thousands of legal alien residents all benefits will be lost even though they have paid federal, state and local taxes. The expulsion of these families from welfare as well as those who have already fallen through the safety net will create enormous pressure on child welfare, juvenile justice, the schools and mental health systems. Many states are already more narrowly defining what constitutes child abuse and neglect as a way of maintaining caseloads at a manageable level. Often neglect cases are viewed as being poverty related and are referred to poverty programs such as Aid to Families with Dependant Children and Food Stamps. With major reductions in these programs and an overall reduction in child care dollars, states will race to the lowest possible rate allowed.

Not only have families been assaulted by these policy changes but the basic values and principles of Family Preservation are also under fire. Welfare as a right and entitlement has

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been replaced with a punitive system. How can this new approach support children spending as much time as necessary with their parents? Where is the belief that families want to change, and often do, by building on their strengths? How can this policy possibly instill hope for families?

Can these new policies and programs really enhance the motivation in families to a greater degree to live as full members of society? Is the families' culture and heritage being respected when they will have to move from rural communities to cities just to find work? It is as if families are being told to swim for themselves in the rough and unpredictable seas of capitalism and the free market. They will be allowed the use of meager life boats for only a few months before they are tossed overboard to fend for themselves among the managed care sharks. Where are the Family Preservation values and principles in the Personal Responsibility Act?

How will Family Preservation stand up to this tidal wave on behalf of families? As Family Preservationists, we must rail against the punitive reforms that are anti-family. We must join in true partnership with families in every community and every state capital to educate and confront the myths of welfare. There is no empirical evidence that these reforms will help families. As Alvin Schorr says, "...only the Congress and newspapers believe there are enough quality jobs with benefits for everyone in this country" (A. Schorr, personal communication, November, 1996). In fact, the Department of Health and Human Services and the Urban Institute predict that over one million children will be pushed into poverty by the implementation of this Act (Bane, 1996).

Next to the families affected by these reforms, Family Preservation workers are, and will be the most expert source on the direct impact of welfare reform on families. We work with these policies at the interface with the family in their own home. What other professional group has this critical perspective? Surely not the in-the-beltway politico's who propose the "traditional family values of the 1950's" and debate TV sit-coms as if Murphy Brown lives in the real world. No, it is those who travel into the neighborhoods and small towns and into the homes and apartments of the poor who know the real story.

We must ferret out and present the facts and the startling brutal realities which result from poverty in this rich country. We must document the results of welfare reform with facts and figures now so that when the cycle of political power comes back around we will be ready with the story of poverty told through pain and suffering of real families.

We know it is no longer enough for us to serve families in their own homes, we must now serve them in every statehouse through our lobbying efforts. We must focus the discussion on the values which underpin the reform. We know the average citizen supports the value of helping their neighbor and those truly in need, yet the general public strongly holds to the welfare Cadillac myths. The inability of the public and the media to integrate the facts in welfare policy indicates the serious need for a thorough and clear discussion of values. What are the real family values and how does the reform damage the families? We need to develop a methodology to bridge the gap between the realities of poverty and the myths of welfare. Who, if not family preservationists, are prepared for these tasks?

Editorial

We believe the articles in this issue will aid us in the task of addressing the impact of poverty by building the capacities of families. Roger Friedman meets this challenge with a thoughtful piece on the status of Family Preservation, where we are going and what we believe in these troubled times. Pamela DeSanto explores Family Preservation with Lesbian Clients and Susan Whitelaw Downs provides guidance to strengthen extended family ties in Family Support Programs. Issues involved in how states are implementing the Family Preservation and Support Act are presented in June Lloyd's article. The reviews of current resources offer additional ideas and inspiration, both of which we will need in the days to come as we in Family Preservation and Support continue to be the primary advocates with so many families.

Alvin L. Sallee

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What's Working in Family-Based Services?--or, What's Left to Believe in During a Time of Such Doubt?

Roger Friedman

This article is a qualitative, personal report from the field, designed to highlight current developments in family-based theory and practice that bring hopefulness to workers and clients. The author, an experienced human services consultant and family therapist, draws from his recent experience in a number of states to identify exemplars of practice in the following areas: integrative theory building, functional family assessment, systems change in regard to inter-agency coordination and foster care, community building in low income neighborhoods, developing humility as helpers, and addressing issues of hope and spirituality with clients and with co-workers. Given the turbulent and hostile political environment for family-based services, this article challenges us to remember that effectiveness in helping others is directly related to our feelings of hopefulness about ourselves and our world.

Introduction

The title of this paper poses two different questions -- one is programmatic and client focused, and the second is personal, and oriented to ourselves as helpers and as human beings. Taken together, these questions reflect my conviction that our effectiveness in helping others is directly related to our feelings of hopefulness about ourselves and our world.

My thoughts on these questions draw on experience as consultant to many family-based services, as trainer in large state social service programs, as family therapist, and as middle-aged father and husband.

Our country's social policies and politics are in stormy waters. The reemergence of states' rights and authority over social spending, the lowering of priorities for human services, the reactive stigmatizing of poor people and in spite of rhetoric, the growing lack of policy concern for children, education, family and community support. Front line workers, supervisors, and state administrators are despairing, asking, perplexing questions--How can we possibly change our bureaucracies to be more humane, coordinated and family-centered? Are privatizing programs and laying off staff the right solutions or are they just conservative efforts to turn the program

clock back to pre-New Deal laissez-faire government? What will be the impact of so-called welfare reform on staff and families? Large federal bureaucracies seem immune from change. How can we keep our optimism and service levels during times of political and fiscal attack on family preservation and family-based services? How can we stay hopeful in the face of so many cut-backs and increasing referrals of traumatized families and children? Is the conservative political resurgence temporary or the wave of the future? Can progressives find a vision that works? There are other deeper, seldom-asked questions that need to be voiced. Why, after all our efforts to shape a better society do things seem to be getting worse? In the wrong spirit these questions invite despair. In another spirit, they call us to ask, "What's working?" What helps staff remain hopeful in such difficult times? When we meet with clients, what are the sources of change that allow us to look forward?

The main thesis of this presentation is that there is a lighthouse out there to guide us, something is working that we can trust -- services that no longer place the professional helper in a central leadership role; services that empower families and communities to help each other; services that invite us to return to hope as being just as fundamental as clinical technique; and services that encourage the helper to be personal and professional. To know what works not only benefits programs and clients, it helps us be better people as well. It focuses us on competency and revitalizes meaning in our work and our personal lives as well.

This presentation is a tentative report or reflection from the field, not a quantitative study. It is anchored in my work over the past few years in Maryland, Pennsylvania, South Carolina, Washington, D.C., Ohio, and New England. The focus is on finding exemplars of practice that work, sensing where staff energy is heading, finding the concepts and skills that are helping, and seeking the complexity and creativity in family-based services. In a way it's like looking at stars with your naked eye. You see patterns, ambient light and beautiful colors. Astronomers know not to look directly at a star, but rather to look a little to one side or the other, and then out of the corner of your eye, you can see what you are really interested in more clearly. So this is research out of the corner of my eye--trying to catch the hard-to-see subtleties, see them clearly, and understand what they are telling us. There are six major areas of investigation I want to report on. The first two relate to theory development, the third area focuses on systems change, and the last highlights specific practice skills.

Integrating Theory

First in the area of theory development, there has been a broad debate from the earliest days of family preservation. This debate was between those who saw a brief, strength-focused model as best served through individual, cognitive interventions, like Homebuilders, on the other hand, and those who saw family systems as the only approach that responded to the complexity of family and community life (Friedman, 1992). These perspectives took training and practice on two different and reductionistic paths during the 1980s and early 1990s that polarized our field.

Cognitive intervention models for family preservation received major foundation funding and established a track record for being cost effective that was appealing to conservative state legislatures. I think of that marriage as an unholy alliance between social progressives and fiscal conservatives. Unholy because progressives tended to oversell their program's effectiveness, and legislators often endorsed cognitive models because they thought it would save the state money.

On the other path, social workers in departments of social services, with high case loads and training in systems theory, viewed the client's world as being shaped by family and community rather than cognitive variables. They tended to cling to a case management/systems approach to family preservation--an approach adaptive to their agency needs, if not always responsive to clients. It has been like the old story of the twelve blind men who each touching one part of an elephant, declared their part to be the total reality. This type of fragmented thought and practice is one of the reasons why family-based curriculum and theory development has lagged so far behind our practice. Consequently, we have remained a methodology encumbered with high values, caught without a home. Unwelcome as too raunchy for academic psychology, and to "upstart" and creative for the ecclesiastical world of social work education.

Family-based services are the neglected children of several disciplines, being shuffled back and forth depending on the politics, professional agenda, and funding of the moment. This has its bright side because we've been free to experiment. However, no synthesized conceptualization guiding our view of development, families and communities was able to emerge after 15 years of practice. This is changing, finally, propelled by experience, wisdom, frustration with the old false dichotomies--a new stage of theory development in family-based services is inexorably entering our conscious view of reality--and this change is one of the things that is working in our field.

Evidence of this change is taking form in the programs that are blending social constructivism and ecological systems approaches and using cognitive and ecological systems strategies for change. Social constructivism assumes that people construct their own picture of reality. This approach leads us to strategies that effect cognitive process and the meaning that people attach to behavior. How we perceive our life situation determines how we feel about possibilities for change in our lives. The focus is on constructing solutions with parents rather than focusing on problems, highlighting strengths, using interviews to identify solutions and setting small realistic goals. By focusing on client's telling their life stories, externalizing depression, learning behavioral techniques for managing anger or despair, we break goals down into steps so small that one must succeed. I recently heard from a social worker who wanted to help a young single parent, mildly retarded mother learn to relax when around her new born--the social worker taught her how to breathe deeply and sing "this little piggy went to market..." when feeding her baby. Her task was to breathe deeply and sing this song for the next day, and when accomplished they celebrated it!

What we call this intervention is important, for I think it carries the hallmarks of good behavioral and constructionist practice--it is concrete and strength building, solution oriented, as focused on the woman's self-concept as it is on good parenting skills. It allows for a mind/body connection that is characteristic of many constructivist techniques. Effective programs are seeing that this type of intervention goes beyond clinical technique. It goes to the core of meaning for overwhelmed parents and children--it empowers and builds on strength. But self talk, cognition, and self-esteem are not enough--these internal concepts of theory do not address the larger social dimensions of the outside world.

Ecological thinking gives us a set of contextual metaphors that describe the influences of different systems levels on the family. It provides a way to view patterns of relationship within the family. Certainly, family structure seen in hierarchy, complementarity, boundaries, and triangles are important. How communities flood or isolate families and provide nurture or toxicity are other parts of this view. Typically, interventions tend to be focused on interpersonal and inter-systems relationships. For instance, in conducting family-school meetings or conjoint family meetings we create a moment of difference for the family. Likewise, reaching out to extended family, team meetings and wrap around meetings--are techniques that derive their approach from ecological thinking. Here we are empowering parents by finding ways to be collaborative with the whole family.

Programs that I see working effectively are adapting both of these approaches and finding ways to blend them. They are training their staff in them, without worrying about illusive conceptual purity. This practice thinking is ahead of documented program models, and way ahead of what is being trained and taught in most psychology and social work schools. Many family-based services are tiring of the old false dichotomies and are approaching practice with a fresh, integrated blend of theory that is commensurate with the complexity of the lives of those we are trying to help.

A Wider View of Families and Communities

A second area I wish to highlight is in how we are moving to define the parameters of family more broadly. Programs work more effectively when they see the family in a functional way, i.e., who ever is involved in raising children should be included as part of the family (Nelson and Allen, 1995). This pushes us to think multi-generationally and include grandparents, aunts and uncles and neighbors. It leads us to reach out to include the men who are never really absent, even though they may not be present in ways that fit stereotypical two-parent family myths. This broad view of the family is especially important when it comes to working with young, single mothers who may technically be referred to as "case head." They really are embedded in a larger system, including a grandmother and great-grandmother, uncles, older brothers, and boyfriends and neighbors. I saw a recent example of this in a reunification program where an oppositional 16-year old daughter was in foster care; her biological mom was often deeply

depressed and overwhelmed with an infant from her current relationship. Mother battled viciously with her daughter over clothes, hair style, high heels, staying out, drugs, etc. Whenever they battled, the daughter would run away into the streets and the mom would become so melancholy that suicide was a real possibility. Instead of focusing on the mother/daughter relationship, the worker began to engage mother's husband, who was the teenager's step-father, as a support for mom, and an aunt to serve as respite care for weekends when tension got too great; the daughter was able to return home from foster care, and the mother began to work more closely with the worker and her husband on ways of managing her melancholy. This functional view of family changes how we relate to the family. The family is now defined less biologically and more functionally as the real souls who struggle together through life. Most staff I work with are intrigued by this variable, but find case studies that end so miraculously more dismaying than helpful. No one can replicate published miracle cures! So I should say that working with an extended family is often messy, exhausting and takes many more phone calls and meetings than staying with the mom alone requires. But it brings us closer to the lives and souls of the families we help, and so it becomes a more relevant way of helping.

The third area of focus in this report is systems change--or how helping agencies can be changed to relate to each other and to families as a supportive rather than fragmenting community (Kagan and Neville, 1993). Programs that are focusing on the inter-organizational field of services, and trying to find ways to intervene in this field are being very effective. There is an inter-organizational web of agencies that exists in all communities that we are aware of mainly at time of transfers or crises. Trying to proactively change this will help families a great deal. Family-based services are finding that family-centered thinking can be a common backdrop for workers in different agencies, and can lead to more permeable boundaries between institutions and communities.

Programs that view the world only through the lens of their own categorical services tend to work with families in isolation from their schools, communities, agencies and churches, etc. That isolationist view makes it increasingly difficult to avoid placements, reunify families and work with any real influence. A more hopeful development is the ambitious cross systems change effort exemplified by the formation of county-wide, inter-agency Family Councils involving education, health, social services, juvenile justice, and vocational rehab councils. In Ohio, sites for administrative and clinical cross systems collaboration projects include joint planning, client advocacy, wraparound planning, cross systems training, case coordination, etc. This type of multi-systems reform needs an environment fertile with political and fiscal support among agency heads and state officials. Family Ties in Boston blends substance abuse and family services in another, smaller scale example of cross-system work. Yet another practice that helps systems change are invitational workshops where staff invite one person from another agency they work with regularly. Likewise, joint picnics and social gatherings, exercises in exchanging staff for the day or having one agency's staff shadow another staff for a day and then debrief over what they've been learning. These initiatives work because they help us to learn about another agency's culture, to appreciate the inter-organizational field and the circumstances

that drive the other agency's perspective and needs. Our goal is to build a sense of community among helpers that transcends agency boundaries. Without that, it is very difficult to enact real collaboration or coordination.

Yet another area of systems change is the conflicted relationships between families and institutions. Many client families are part of communities and participate in institutions but tend to be excluded or scapegoated in these contexts. The challenge is to help those polarized relationships become more collaborative. Effort is spent on bringing parents and teachers together, linking up church leaders with families in need of help, connecting family members to self-help programs and neighborhood helpers, organizing team meetings and wrap-around meetings, where parents and children are empowered to play a joint role in the setting of goals and implementing plans. These techniques are important and effective tools--they are needed and more importantly, they are working in systems change.

A fourth skill area is the challenge of becoming community builders with the neighborhoods we work in (Bruner, 1996). This means seeing ourselves as community members, and where possible, facilitating groups and small systems of relationships. Increasingly, programs are more effective if they are able to see and help facilitate the formation of natural support groups in housing developments and neighborhoods. A good example is the formation of teen clubs and activity groups in transitional housing programs. These groups provide a sense of positive community. They nurture types of interactions among young people and between adults and kids that we expect for all of our children.

Here's a note from Meiesha, a 13-year old recently elected president of a new teen club in a transitional housing program in Maryland. The families live for a year in a subsidized apartment in a housing development with support from family preservation staff and then are expected to move into their own living space. Most of the families are involved with child protective services for neglect or abuse and have extensive substance abuse histories. Meiesha writes to the kids in the new club with excitement. This positive peer group represents a new way of relating and a vehicle for belonging, self-help and pride.

"HEY TEEN CLUB. SETTLE DOWN.
I HAVE SOMETHING TO SAY NOW THAT I HAVE BECOME PRESIDENT.
WE WILL NOT BE TALKING ABOUT EACH OTHER ANY MORE.
NOW WE ARE A TEAM
NOT A CLUB THAT FIGHTS. THERE WILL BE NO YELLING,
SCREAMING OR HITTING
NOW I HAVE SOMETHING TO ASK YOU.
DO YOU WANT TO BE PROUD OF YOURSELVES?
WE CAN LEARN A SONG? HOW ABOUT MY COUNTRY TISS OF THEE,
LIFT EVERY VOICE AND SING, OR AMERICA. ANY SUGGESTION?
LET'S SHOW THE STAFF WHO WE ARE AND WHAT WE CAN DO!

THE TEEN CLUB IS TO LEARN, HELP AND MAKE THE WORLD BETTER.
AND WE STRIVE!!!!!!!!!!!!!! A MATTER OF FACT HOW DO YOU FEEL ABOUT ME
BEING PRESIDENT OF OUR CLUB?

YOUR PRESIDENT,
MEIESHA

Here, Meiesha is leading us. Other community building work is being done by Settlement Clubs that encourage families to create rituals to celebrate achievements--an example is Rites of Passage clubs for teenagers where teens explore both loyalty and the realities of growing up together including grieving together for community members who have been killed or hurt seriously through violence. Traumatic attack, loss and social isolation is so prevalent in many low-income communities, that families need connection, intimate interaction and a place to share sorrow and joy with others in the same situation. Meiesha says there is a difference between being a gang and being a group-- when family-based programs engage in this kind of work they add multi-levels of effectiveness to their efforts. This part of our hope in action is very exciting.

Finally, community building is a way of changing small helping systems when children must be placed out of the home for safety. New Family-to-Family projects are redefining foster care, from fragmenting and disempowering birth families, to creating a collaborative relationship between a community family and the child's birth family. Whenever a child goes into foster care, a new system is created that includes the agency worker, the foster family and the biological family (Minuchin, 1990). Traditionally, this triangular system is full of distrust, fragmentation for the family. The worker is most powerful. The new model of foster care focuses on expanding the role of the foster family to become a long-term network of support with the biological family. Naturally, the social worker is less central. It facilitates foster parents to engage biological family parents in personal ways that professional helpers are unable. A colleague tells me that after 15 years in foster care, he was asked to supervise a new family-to family foster care program. On cleaning out his desk, he found a 1981 memo telling staff that under no circumstances should foster parents and biological parents meet. In amazement at how archaic this sounded, he looked to the top of the memo and realized he had written it! A paradigm has really shifted. All of these newer different community building efforts focus on professionals helping community people relate to each other in more healing ways. The old model of professionals controlling interactions, with all the knowledge to heal the world, is bankrupt. We must face this and find how to use ourselves in richer more humble ways.

The Heart of Helping

The fifth area of effectiveness that I see out there, emerges from working collaboratively and with humility with families. It is very difficult to balance one's professional role with the need

to empower. This is easier "to talk" than it is "to walk." We know that the concept of complementarity teaches that as long as there is hierarchy in our relationship with clients, we will be the expert and the other will be the lost child. But the hierarchy has its value, for if we totally reject this hierarchy, how are we to behave with families? Would we find ourselves as overwhelmed and lost as they? Would we become a part of the family, tossed and turned by the shifting coalitions and pain that the family experiences? To some degree the answer here is yes, for we must allow ourselves to enter the family's world without the protection and boundaries of expert roles. An expert role leads us to view life as a matter of therapeutic change, not the mix of mortality, meaning and survival that it is. To do this, when visiting the family's home, we must operate in ways that gives the family leadership, that joins in the flow of family life, disclosing some of our own experiences that match with the family's, allowing our sadness and anger to show, accepting that we are not experts, just helpers with different experience (Kaplan and Girard, 1994). For many of us this means shedding years of professional socialization and thought patterns that focuses only on deficits and therapeutic change. It has been hard for me to give up the pleasure and authority I find in being called "Doctor" with families--but as long as I introduce myself that way, I create a hierarchy that is difficult to change. If by "Doctor" I imply an ability to diagnose, prescribe, and fix a family or child, I am not only overselling my skills but fooling myself as well. After 20 years of practice, I am finding a kind of humility in my work that is full of anxiety and opportunity. Anxiety in that I must face long-suppressed feelings of self-doubt, and opportunity because new possibilities are emerging in how I relate to clients. After all these years, now I begin to see myself more clearly.

And yet, we do know some things about human development, parenting, and working with crises--can't we impart our wisdom and try to help families benefit from what's been learned by others? There is some science to our work that we can bring to parents and their children though not as much as we've thought. Balancing our perspectives and roles is difficult and the programs that encourage their staff to talk openly and honestly about this dilemma are most effective.

During consultation meetings with staff, I will spend time focusing on what you know clinically that can help this family. Then I ask, what as a person, aside from all your technical knowledge, can you offer this family? What about your life story, your hopefulness, your personal experiences of survival, defeat and recovery can you share person to person with this family? And then, who in this family has something to teach you and how can you go about this process of learning? We must ask these questions of ourselves as helpers--so we can enter families' lives with humility, and a combination of science and authenticity. When we do this or even try hard and fail, we are more likely to be effective with clients and more able to live fully ourselves.

The final area of skill development that I see working in family-based programs is related to this, but a different shade. It has to do with finding the courage to express issues of meaning and faith with clients and among ourselves--to notice how our work impacts our outlook on life, and to face our own needs to be hopeful if we are to help anyone else. The splitting of the

clinical versus spiritual in our training and work has left us disassociated from, and ill-equipped to help families whose major resource is their faith in God or a power larger than themselves. We train to help others, and rarely do we focus on how to engage these deeper issues in clients' lives or our own (Swenson, 1995).

The trauma of many family's lives eventually has its impact on us as helpers--we become numb, lose compassion, and avoid feelings. After a while we talk privately with a friend or keep it all to ourselves--certainly such pain is not welcome at home, not over the dinner table with our spouses or children, not at parties when someone asks "so what kind of work do you do" (Erikson, 1994). Programs that are effective are beginning to form support groups, response teams, are accepting our own need to find hope as helpers--to discuss how the trauma our clients face remind us of traumas in our own lives. To explore together how spirituality helps us live and care with existential crises.

In a recent group discussion among in-home services staff, we first spoke of the trauma of clients and talk shifted to discussing our own traumas--most of those in the room had experienced assault, painful loss, violent act, or major illness that was on their minds and that had been brought back to consciousness by encounters with clients. What happens with this underbelly of emotionality that is present in all family-based agencies but often goes unacknowledged and unexplored? We separate work from this part of our life, and our work loses meaning and so does life (Jay, 1991).

Staff groups that are able to address these issues are more hopeful with clients, but are also more hopeful as people. Our modern cultural tradition of privatizing and seeking psychotherapy for trauma, helps us medicalize what are also existential dilemmas. If we are to have long and meaningful careers, we must find a way to help ourselves carry the trauma of work, soothe each other's wounds, and appreciate our scars as the hard-earned texture of wisdom. With this we become compassionate helpers.

Reflections on Hopefulness

The main theme of this presentation has been that there are areas of much hopefulness in family-based services. What is working are services that no longer expect the worker to be the sole expert, that blend personal and professional, spirit and science, and that empower families and communities. These areas are evidence of new development that are hopeful and far-reaching in their impact. We in family-based services are recreating ways of helping that enrich human services and our own lives.

I want to conclude with a story from my own family. Over the past several years, my oldest daughter, a pre-teen, has become an active reader of wonderful literature; the *Anne of Green Gables* series, *Little Women*, the poetry of Robert Frost. We decided to read a book together,

and chose the *Diary of Anne Frank*. My daughter, like Anne, sees herself as a writer and is keeping a diary during exactly the same adolescent years as Anne Frank. We are reading the diary also because we are Jewish and this spring our family will celebrate her Bat Mitzvah. Reading the book together is a way to explore our Jewish experience and the big questions of growing up, life and death.

As you remember, Anne, her parents and her sister Margot and a family of friends, go into hiding in Amsterdam in May, 1942, 56 years ago. The Germans have taken over Holland and are deporting all Jews to concentration camps in Austria and Germany. The family remains in hiding, never leaving their secret annex, for just over two years--Anne turns 15 in hiding, and her writing becomes more sophisticated, thoughtful. It is full of life and hope throughout. Anne created a private soulmate in her diary and addressed each entry to this soulmate who she called "Kitty". Finally, Anne and her family are discovered in August of 1944, and all but the father perish in the concentration camps the next year, only two months before American and Soviet soldiers arrive.

In talking with my daughter after we finished reading, I said how sad I felt--knowing the ending before Anne did, feeling the pain of her loss and the destruction of the Jewish community in Europe. My daughter said to me that she did not feel so sad reading the book. After all, Anne wasn't sad, she lived a really full life in the annex, she didn't know when she was going to die and besides she said she couldn't pay attention to that anyway. My daughter said that we all are like Anne, we never know when we will die--maybe tonight, maybe tomorrow--and if we focus on that, we won't be able to live fully today. She said I'm going to do just what Anne did--and she reminded me of one of Anne's last entries before they were discovered--it goes like this:

Dear Kitty:

...People who have a religion should be glad, for not everyone has the gift of believing in heavenly things. You don't necessarily even have to be afraid of punishment after death; hell and heaven are things that a lot of people can't accept, but still religion, it doesn't matter which, keeps a person on the right path. It isn't the fear of God, but the upholding of one's own honor and conscience. How noble and good everyone could be if, every evening before falling asleep, they were to recall to their minds the events of the whole day and consider exactly what has been good and bad. Then, without realizing it, you try to improve yourself at the start of each new day; of course, you achieve quite a lot in the course of time. Anyone can do this, it costs nothing, and is certainly very helpful (Frank, 1986).

Love,

Anne

My daughter said that this was the lesson for her of Anne's Diary, that no matter how hard things got in life, she would try to go to bed each night thinking of the good she did that day and planning how she could be better the next day. I knew in that moment that our roles had switched, that I was learning about hopefulness and how to live life more fully from my 12-year old daughter. She was now the wise teacher and I the lost child. In such moments of caring across generations, of compassion for each other, of vulnerability about the big questions of life, we become aware of what makes our own and our client families work--and also, of what there is left to believe in.

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The Family Preservation Philosophy and Therapy with Lesbian Clients

Pamela DeSanto

Family preservation is generally viewed in terms of a rather narrow practice definition. However, its underlying philosophy offers a strong framework for building a positive, non-biased helping alliance with lesbian clients in a therapeutic setting.

The family preservation philosophy offers a unique heuristic for helping professionals to work with lesbians. Family preservation values teach that the therapist must start with the client's reality, recognize the particular needs of that client, and use the client's strengths in treatment. Also inherent in this perspective is respect and sensitivity to the lesbian client's "cultural context, experience, and history" (Family Preservation Institute, 1995). In other words, in the family preservation philosophy there is no assumption of heterosexuality in the therapeutic relationship; rather there is an assumption of unconditional positive regard. Further, clients are engaged in a dialogue and encouraged to name the challenges they encounter in their own words, from their own perspective. All of these principles will help empower lesbian clients.

Lesbians may avoid traditional mental health services in times of need, preferring to depend on alternative services or friendship support networks. The choice not to seek help through mainstream agencies may be based on previous negative experience or on an assumption of the homophobic attitudes which are often inherent in such services. Traditional services are usually based on the medical model. Services based on the family preservation philosophy, however, have the capability of creating therapeutic relationships in which there is no assumption of heterosexuality, where the lesbian client is respected and viewed as a whole, healthy individual.

Lucas (1992) estimates that 2-6% of American women are exclusively lesbian and that 20% of all women in the United States have had some lesbian experience prior to the age of 40. Factoring in family, friend and collegial relationships of the identified lesbian population results in an even larger segment of the population in which therapists are likely to encounter lesbian issues. This is a significant prospective client base which is, in fact, increasing (Laird, 1993). Therapists may be involved in a direct practice relationship with a lesbian client or her family members. And, increasingly lesbian couples are having or adopting children.

The social work mission addresses many facets of the profession, particularly values and ethics, diversity, social justice, at-risk populations, and individual empowerment. Each of these tenets is an essential consideration for therapists engaged with lesbian clients. This is especially important when viewed in terms of the philosophy of family preservation, which focuses on

practice "guided by values which uphold the uniqueness, dignity, and essential role which families play in the health and well being of their members" (Family Preservation Institute, 1994). Therapists possess biases which they would do well to acknowledge and process to be effective in the helping alliance. This requires self-exploration and "identification of personal homophobia" (Falco, 1991), acquisition of accurate, factual knowledge, and use of affirming language which does not assign negative, clinical labels.

Increased insight gleaned from client's experiences may help improve services and treatment modalities for lesbians from a cross-cultural perspective. Understanding and validating the lesbian client's views and incorporating them into practice may significantly enhance service provision to this significant nonethnic minority group.

Defining Lesbian

There is no single definition of lesbianism. Removing it from the typically accepted context of strictly sexuality, Tully (1995) states that it also encompasses "a more comprehensive view of women-identified women that can include spirituality, politics, emotions and intellect" (p. 1591). Ferguson defines a lesbian as "a woman who has sexual and erotic-emotional ties primarily with women or who sees herself as centrally involved with a community of self-identified lesbians . . . and who is herself a self-identified lesbian" (Golden, 1987, p. 21).

Nor is there one all-encompassing descriptive profile of a lesbian; lesbians run the gamut of ethnicities, socioeconomic levels, disabilities, religious upbringing, age, education, and so forth (Falco, 1991; Tully, 1995). Lesbians are also engaged in a wide variety of professions and activities, and a great proportion do not fit the physical stereotype which is imposed on them. Lesbians are, however, different from nongay women in many ways, in terms of the reality of living with internal, institutional and societal oppression, discrimination, hate and fear.

Lesbian Mental Health

While prior to 1973 the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association categorized homosexuality as a mental disorder, studies show no significant differences in psychological adjustment and well-being of lesbians and nongay women (Wayment & Peplau, 1995; Rothblum, 1994). Lesbian clients bring to the counseling process many of the same problems as nongay clients. However, the therapist must not ignore the client's lesbian orientation; leaving this important information out will impede the therapeutic process and may keep the client from progressing by not dealing directly with who she is. And, even when the client's issues are not related to sexual orientation, the therapist needs to remember that the impact is heightened by the fact of living in a homophobic society.

Viewing the lesbian client as healthy will focus treatment on the presenting problem and not on finding the cause of gayness (Kaplan & Saperstein, 1985). This will also help put the client's

sexual orientation more appropriately in context, helping dispel the idea that gayness is always a choice, and reminding the therapist of Kinsey's perspective that sexual orientation is fluid over a continuum and not fixed (Goodman, 1985). Falcos states, "Lesbian affirmative practice is a frame of reference, not a technique" which "involves the knowledge, skills and attitudes of the therapist" (1991, p. 31-32).

Reframing Fusion

Nichols and Schwartz define fusion in terms of family therapy processes as "a blurring of psychological boundaries between self and others" (1995, p. 592); the traditional therapeutic view has been that fusion is a symptom of dysfunction in family relationships. However, lesbian psychologists have identified fusion not as a sign of dysfunction, but rather as an outgrowth of a relationship between two women, behavior which accommodates the probable reduced social structure of lesbian family life and lack of acceptance of the family by society. If a therapist is able to reframe fusion to a positive interpretation, one of adaptation, perhaps, work with lesbian clients is likely to be more successful. By viewing fusion in a lesbian couple from a perspective of strength and understanding of its function, the therapist may help affirm the relationship, acknowledge the impact of societal homophobia on the family, and thereby enhance the strength of the therapeutic alliance.

Coming Out

It is often assumed that a lesbian's psychological well-being is directly connected to her level of outness (Falco, 1991). Spaulding (1993) describes a lesbian's coming out as the development of a new definition of self, a sense and image of self, behavior patterns within and outside the lesbian community, and a redefinition of self in the context of family of origin. Variations in the process depend on many factors, including family, religious background, health, previous hetero- and lesbian sexual experience, age at recognition of lesbian orientation, and even political climate. It involves resocialization and, to some extent, a return to adolescence (Spaulding, 1993; Browning, Reynolds & Dworkin, 1991).

It is also a time when existing familial and friendship relationships are tested. As a result of coming out, a woman's lesbian identity may be embraced, accepted, or, she may be rejected.

While adult lesbians are generally on their own and not dependent on family for basic needs, becoming invisible in the family of origin deprives them of their most basic human connection and nurturing environment. Fear of this loss often keeps lesbians from coming out completely; with selective, ongoing assessment of how friends and relations will react. This "secret" becomes a complex juggling act for the woman, who must keep on her guard and remember who "knows" and who does not. All of this may take a toll on her sense of self worth and security.

Lesbians and Traditional Mental Health Services

Lesbians have been called the invisible minority in a system of care which assumes heterosexual orientation (Robertson, 1992). Traditional mental health services are problematic for lesbians for several reasons: open gayness is still socially stigmatized, practitioners often lack accurate information about gayness, and, because of their own fears, therapists may provide misinformation to both lesbian and nongay clients (Child Welfare League of America, 1991). Falco (1991) reports that in a 1988 study by Jensen and Bergin of 425 therapists (including psychologists, psychiatrists, clinical social workers and marriage and family therapists), 57% of those responding defined a healthy lifestyle as one which included a heterosexual relationship.

Many lesbians hesitate to reveal their sexual orientation to practitioners because of the personal risk involved, emotionally, physically and professionally. A recent study showed "a repertoire of strategies" for safety, including seeking practitioners of similar orientation and experience, and becoming "attuned to subtleties in language, manner, and emotional atmosphere, monitoring for signs of ignorance, [and] prejudice" (Stevens, 1994, p. 222). Falco (1991) cites 1973 findings by the Boston Women's Health Book Collective wherein the lesbian community referred to therapists as "the rapists of the lesbian identity" (p. 20). Therapists have responded to disclosure of lesbian orientation by avoidance, ignoring the client's lesbian identity, with lectures about an unhealthy lifestyle, and even exhorting the client, "You're not a lesbian!" (Falco, 1991, p. 43-44). Further supporting the lesbian client's hesitancy to divulge her orientation, Klein (1986) notes a variety of techniques historically used to cure homosexuality, including incarceration, hospitalization, aversion therapy, electric shock, frontal lobotomy, drug therapy, and psychotherapy. Lesbians have also been subjected to treatments such as hysterectomy, removal of ovaries, and clitorrectomy (Falco, 1991).

There are, however, beneficial aspects to lesbians using traditional mental health services. Encounter with a lesbian affirmative agency or therapist may help a lesbian feel validated. And, the experience therapists gain may help them become more aware and more comfortable with this population. It is hoped that increased contact will motivate the agency to advocate for better services and training (Grace, 1984).

In 1986, the American Psychological Association Task Force on Heterosexual Bias in Psychotherapy conducted a survey of members and results showed that the 1,481 psychologists in the sample differed widely in terms of gay affirmative practice. Ninety-nine percent of respondents had treated at least one gay or lesbian client. The study found gay affirmative practice but also considerable bias, inappropriate and inadequate practices, and lack of understanding of lesbian issues in terms of both assessment and intervention; 58% had personal knowledge of cases where therapists had provided biased treatment (Garnets, Hancock, Cochran, Goodchilds and Peplau, 1991). Findings indicated that a significant percentage of the therapists saw sexual orientation as a problem, provided wrong information on lesbian issues, held negative views on lesbian parenting, and lacked an understanding of the impact of

homophobia on the gay or lesbian client (Corey, Corey & Callanan, 1993, p. 271). Certainly, lesbians suffer from real psychiatric disorders just as nongays do, but primary treatment issues frequently relate to difficulties caused by misconceptions and the societal hostility and fear directed toward them, resulting in self-esteem problems, feelings of rejection, isolation and anger (Klein, 1986; Browning, Reynolds & Dworkin, 1991), and a hesitancy to rely on traditional treatment systems.

In the therapeutic milieu, lesbians may face double discrimination due to their gender and their sexual orientation (Spaulding, 1993). And, for lesbians of color, there may be triple discrimination (Falco, 1991). This is, to a great extent, a result of the entrenched institutional sexism inherent in many therapeutic theoretical frameworks, and a system which labels male-identified characteristics as healthy but devalues them when seen in women (Brooks, 1981). Much of the traditional mental health system is based to some extent on Freudian theory which is detrimental to women in general, and lesbians in particular. Freud considered lesbians to be immature and incomplete. Lesbianism, by definition, is in opposition to the stereotypical expectations of women which are ingrained in the patriarchy-based American society (Falco, 1991). Power is an issue in the traditional therapeutic relationship. "In traditional therapy, therapists have power, and this power can be used to push lesbians back into the closet and away from a positive, integrated, woman-identified life" (Girard & Collett, 1983, p. 48).

The commonality to be found among these studies is the reality of discrimination and homophobia faced by lesbians in day to day life, including in securing mental health services. The studies also illustrate the resiliency of lesbians and their level of commitment to each other, their families, and their community.

Family Preservation Philosophy and Lesbian Clients

Sophie states that "the therapeutic relationship is itself a treatment modality" (1988, p. 54). The implications of homophobic therapists treating lesbians are far-reaching, particularly in view of a study of 140 mental health professionals which reported social workers to be the most homophobic, while psychologists were shown to be the least (DeCrescenzo, 1985). Homophobia on the part of a therapist has a negative impact on the therapist/lesbian client relationship through stigmatization and unequal treatment and restricted ability of the agency to provide appropriate services (Moses & Hawkins, 1985, p. 155-156).

The Code of Ethics of the National Association of Social Workers (NASW) clearly mandates member practitioners to work against oppression and provide unbiased, empowering assistance and advocacy to all clients, regardless of status or sexual orientation. Social work's mission addresses values and ethics, diversity, social and economic justice, and respect for the individual (ie, start where the client is). The basic philosophy of social work, and in particular family preservation's strengths perspective and emphasis on cultural competency, support lesbian affirmative practice.

Even more specifically applicable to work with lesbians is the philosophy of family preservation, which is "guided by values which uphold the uniqueness, dignity and essential role which families play in the health and well being of their members" (Family Preservation Institute, 1995). Also central to the philosophy is an expanded definition of family and respect for the dignity and privacy of each family member. Finally, traditional models see the therapist as the expert; family preservation regards the client as the expert about itself, and, as stated above, approaches the process from a strengths perspective rather than the traditional deficit model.

These principles are of critical importance when working with lesbian clients because of the institutional homophobia this population often faces when seeking services. Service providers must respect the efficacy of the lesbian and her family, also integrating the reality of the changing profile of the American family into practice paradigms. They would do well to recognize the special strengths lesbians possess which enable them to overcome the constant negative messages they encounter, and use these strengths in treatment plans and helping relationships. It is also beneficial for therapists to view lesbianism in a holistic sense. Lesbianism is more than merely sexual behavior; it encompasses all facets of the individual woman's life. This client is a complete person, grounded in her own reality, possessing exceptional strength and courage.

Nevertheless, regardless of the prescribed ethical guidelines, many helping professionals still view homosexuality as a disease which must be cured, and, while conversion therapy is less prevalent today, use of this modality still occurs. A 1984 study of 112 psychotherapists in Cincinnati, Ohio by Graham, Rawlings, Halpen and Hermes showed that 62% believed therapy could change sexual orientation (Falco, 1991). Inadequate knowledge about lesbians is still a major factor in the homophobic attitudes of therapists. Lesbian affirmative practice recognizes that lesbianism is a valid expression of sexuality, that most lesbians are emotionally healthy, and that oppression is an every day occurrence in a lesbian's life (DeCrescenzo, 1985). Goodman (1985) proposes that agencies could greatly enhance gay affirmative practice by helping therapists recognize, assess and acknowledge their own attitudes, offering appropriate training, and providing factual information to dispel myths and wrong assumptions.

Expanded Definition of Family

The family preservation model uses a definition of family which embraces not only the traditionally accepted stereotype of family, but also all possible combinations and descriptions. The most important defining factor is that the unit views itself as a family. This has been an area of great distress for lesbians, lesbian couples, and lesbians with children, in that society generally does not recognize, accept or define them as families. In fact, around 3.5 million gays and lesbians have children (Women's Action Coalition, 1993), and this number is steadily increasing. Again, the lesbian family may be invisible in society, which sometimes strips away

support systems which are assumed by heterosexual families. The family may, in fact, be viewed wrongly as a single parent family. (Crawford, 1987). Kirkpatrick (1988) cites Lewin's findings that lesbian mothers depend on family supports more than supports from within the lesbian community; the lesbian community tends to be more adult focused and mothers may feel out of place.

Wayment and Peplau (1995) discuss a study by Aura of 664 women in southern California in which lesbian and nongay women reported similar levels of social support, and showed that a higher level of social support was correlated with increased feelings of well-being. In this study, lesbians indicated a greater need for "reassurance of worth," defined as "receiving respect and praise, having people know 'the real you,' and receiving support for behaviors that are nontraditional for women" (p. 1198). This seems logical in the context of the differing social roles of lesbians and nongay women.

Recognition of an expanded definition of family is an essential ingredient in working with this population. Validating the lesbian family as a viable unit worthy of respect and support can lay the groundwork for establishing a strong, healthy family unit.

Strengths Perspective

Lesbians have many special strengths. They must possess well-honed survival skills to flourish in an environment of homonegativity and to overcome the illness model by which they have historically been judged. Lesbians are all but invisible, without identity, in traditional paradigms (Muzio, 1993). The family preservation philosophy fosters a redefinition of the traditional view and emphasizes instead the strengths which enable lesbians to create and maintain families.

Gergen and Kaye state that people who enter therapy "have a story to tell" (1992, p. 166), and the strengths perspective encourages reframing of experience. Such restorying can have a significant impact on work with a lesbian client, providing an opportunity to place her story in a positive context rather than adhering to the old version with its negative connotations.

Cross-Cultural Competence

Another important aspect of the family preservation philosophy is cross-cultural competence. The lesbian community is often referred to as a subculture and lesbians may be considered a nonethnic minority (Atkinson & Hackett, 1988). Studies show that client perceptions of the attitudes and beliefs of the therapist may have a significant impact on the process and outcome of service. Kaplan and Girard (1994) note that "lack of understanding can create barriers to service delivery" resulting in client dropout (p. 89), and Allen (1993) states that "it is the ethical responsibility of the clinician to . . . foster an atmosphere of respect for a multiplicity of views" (p. 38). Axelson (1985) discusses the idea of "synergetic counseling" (p. 336-7), a blending of

helping behaviors and therapist reality with the reality of the client. He believes that in an effective therapeutic relationship the therapist accepts and validates the client's reality of self, not society's.

Hardy (1989) discusses the problems created by the "neglect of context" in family therapy with minority group families, where the therapeutic relationship may be seriously compromised by inattention to cultural issues. In addition, the idea of the "theoretical myth of sameness" is introduced, referring to the tendency of therapists to attempt to incorporate all clients into the dominant paradigm, and, further, to stereotype them within an alternative paradigm as well. This issue is of particular importance in working with lesbian families, especially in terms of the low level of societal acceptance and support they experience; formerly married lesbians may be faced with harassment and legal battles to retain custody of their children. They fear losing the battle - and their children - despite evidence that children raised in lesbian households tend to be more flexible and more accepting of differences in other people (Laird, 1993).

The homophobic experiences and the vulnerability of lesbian clients must be understood clearly by helping professionals and not underestimated. The undercurrent of fear and oppression that lesbians must deal with in every aspect of their lives is heard in the voices in this study and must not be minimized.

The overwhelming strength of lesbians - no matter what their level of outness - must also be recognized and integrated into the helping process. The fact that most lesbians are able to function and thrive despite their societal status as a feared, hated and often ignored minority, with the courage to live and love as they must, displays remarkable resilience. These ego-strengths may be further enhanced by lesbian affirmative therapists and agencies; such positive experiences may help break down not only institutional homophobia but also the personal homophobia of therapists and the internalized homophobia of the individual lesbian herself.

Lesbian Affirmative Practice

Therapists must remember that many of the accepted views about sexual orientation, gender identity and masculine and feminine roles are created and defined by society; it is society which has labeled gayness as deviant. Therapists must also recognize the extent to which their own views are biased by the dominant culture; biases and personal uncertainty must be dealt with in order to work successfully with lesbian clients. This internal work by the therapist should be done outside the therapeutic milieu, and it is the first, most vital step in developing a lesbian affirmative practice modality.

A client centered approach seems most beneficial with lesbians, with treatment based on the principles that lesbians are basically healthy and happy, that sexual identity is just one aspect of an individual, and that the counseling environment is supportive and non-judgmental (Klein, 1986).

While there is without question a need for more openly lesbian therapists, it must be remembered, too, that certain clients will be uncomfortable with an openly lesbian therapist, who must be sensitive to this issue. Lesbian therapists, just as those who are nongay, must also come to terms with their own sexuality and their internalized homophobia.

In practice, in addition to honest self-assessment of personal beliefs, value systems, and sexuality, the therapist must also acquire at least basic information on homosexuality to dispel possible myths and misconceptions. A knowledge and understanding of the history of oppression which lesbians have experienced is also important.

Further, the therapist should become familiar with local, statewide and nationwide resources. Creating a resource list is imperative in view of the isolation and discrimination which make it difficult for lesbian clients to access many services. It is a critical order of business for the therapist to research lesbian-friendly providers such as physicians, attorneys, and spiritual guides.

Goodman (1985) suggests that traditional mental health agencies may become more gay affirmative if administrators are attentive to helping therapists recognize homophobic attitudes, encourage self-assessment, and increase level of sensitivity to gay and lesbian issues. Intra-agency training programs may provide concrete information and an opportunity for values clarification to reframe stereotypes and portray lesbian clients as healthy people.

Conclusion

Lesbians live in a world where heterosexuality is assumed not only by friends, family, and coworkers, but also by service providers. By recognizing the special needs - but at the same time removing the stigma of difference imposed by society - therapists may help lesbian clients to more fully view themselves from a positive, empowered stance.

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Parenting Pioneers and Parenting Teams: Strengthening Extended Family Ties in Family Support Programs

Susan Whitelaw Downs

Starting with the premise that extended family members often have great influence on family functioning, this article describes social work practice techniques for helping families utilize resources available in the extended family network. Two key concepts are presented: "parenting pioneers," who, while attempting newly learned parenting skills, may struggle with resistance from extended family members; and "parenting teams," in which the focal family is giving to or receiving from extended family members substantial family support. The article presents these practice techniques in the context of family support services, which are characterized as voluntary, preventive, developmental, and based in the concept of empowerment and the ecological perspective.

As family preservation continues to be the preferred option of child welfare policy makers for children needing protection, it becomes increasingly clear that family support programs represent the "first line of defense" in the effort to preserve families and prevent the need to place children outside their family (Massinga, 1994). Recent federal legislation reinforces the importance of family support in the community's continuum of family and child services (Golden, 1994). To fulfill their mission, family support workers need to develop assessment and intervention skills not only with nuclear families, but also with the extended families which surround and support them.

Family support services have proliferated during the 1980s and 1990s, in response to social and economic trends that have negatively affected families. Increases in single parenthood, in family relocations in search of jobs, and in health epidemics such as substance abuse and AIDS have

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left many families socially isolated and vulnerable to social breakdown. They may be without the strong extended family and neighborhood supports which helped earlier generations of families to raise healthy children. Family support programs attempt to fill this gap by providing accessible, informal, user-friendly support services to families (Allen, Brown & Finlay, 1992; Golden, 1994; Kagan & Weissbourd, 1994; Downs, Costin & McFadden, 1996). As Norton (1994) has pointed out, a key challenge of the family support movement is the professional development of staff with skills needed to work effectively with families. She identifies a major area for worker knowledge and skill as the understanding of "the universal value of support" (p. 423). This paper is intended to help family support workers and child welfare workers recognize the potential of extended family systems to support families, and to suggest ways that worker, the family, and the kin network can collaborate to strengthen family functioning.

Extended family members often have a great deal of influence on the family, an influence which is likely to continue after the family support intervention has ended. Relatives are sanctioned by culture and custom as the primary source of advice, support, and supplementary resources for families. The best way to strengthen family functioning may be to strengthen the support network of family and friends which surrounds the family being served by the program (Thompson, 1995).

Adding to the importance of workers' acquiring skills in working with extended family members is the increasing emphasis in child welfare on placing children in need of out-of-home care with kin providers (Johnson, 1994; Downs, Costin & McFadden, 1996). For some troubled families, the family support worker and the extended family, working together, may provide sufficient support to prevent the need of out of home care for the children. In other situations, the prior work of the family support worker in strengthening the extended family system may open appropriate options for placing the children within the extended family if out of home care becomes necessary.

Family Support Practice Involving Extended Families

Family support services are very diverse. They may be located in welfare agencies, schools, health clinics, mental health centers, family service and other types of community-based agencies, or they may stand alone. The services may involve drop-in programs, support and parent education groups, or home-visiting, and may include a component of direct services to children. They may have a specific focus on families with infants, young children, teenagers, or children with developmental disabilities (Weiss & Halpern, 1990; Downs, 1994). Whatever the specific program components, family support programs are characterized by their dual goals, as identified by Weissbourd and Kagan (1989):

- **Promoting development:** to help families learn ways to encourage the optimal personal development of all family members; and
- **Preventing problems:** to help families prevent negative outcomes such as abuse and neglect, family violence, substance abuse, delinquency, and school failure.

These goals are supported by certain basic principles which guide family support work. The principles are presented below, along with a brief discussion of the implications of each principle for working with extended family systems (Weissbourd & Kagan, 1989; Norton, 1994).

Basic Principles of Family Support Services

- **Empowerment.** Family support services use an approach which emphasizes family empowerment. The family is considered to have the knowledge and strength to identify and find solutions to problems; the worker facilitates this process and provides information to the family to help it meet the goals that family members themselves have set. Extended family members may possess strengths and have knowledge which will help the family resolve identified problems (Cochran, 1993).
- **Ecological perspective.** Family support services have an ecological view of child development which holds that the family, to fulfill well its child rearing function, needs to be embedded in a supportive environment which may include extended family members, friends, faith communities, and adequate public services and resources. Effective interventions work to build a more adequate support network around the family (Bronfenbrenner, 1987). Family support approaches recognize the universal value of support, and build on the existing support network among family members in planning interventions (Weissbourd and Kagan, 1989; Norton, 1994).

The Triad: Focal Family, Extended Family, and Family Support Worker

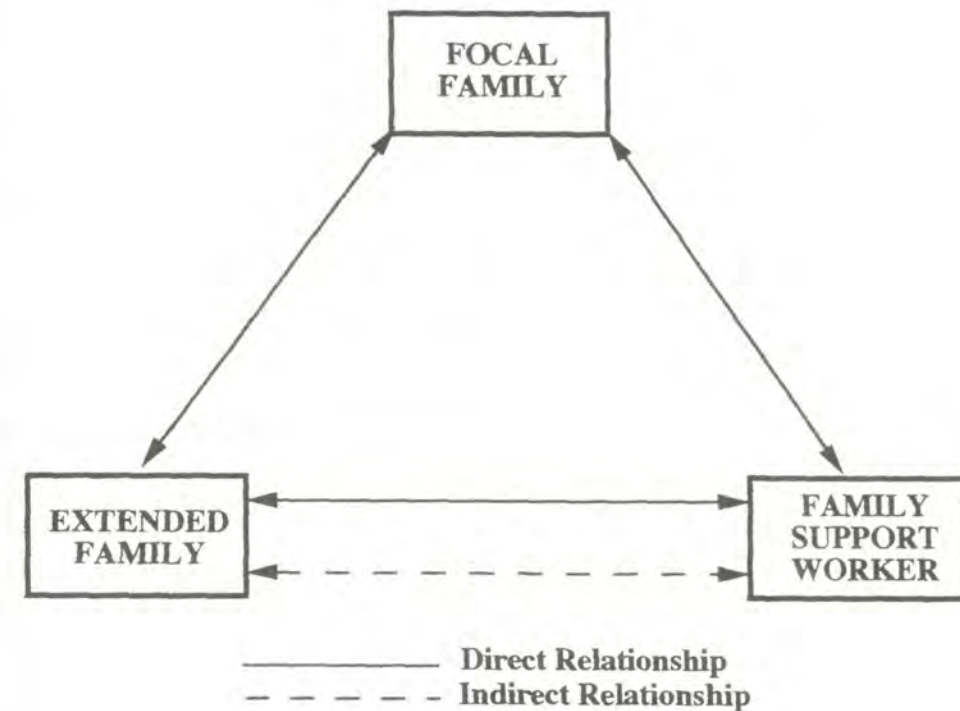
Family support workers typically offer a variety of services to families, including parenting education, individual supportive counseling, help with family needs for concrete resources, referrals to other community services, and guidance on adult education and employment. These services are offered through a voluntary, informal approach, with the overall goals of preventing family breakdown and promoting the optimal development of all family members. Family support services may be offered by broad-based ameliorative and preventive service programs, such as those offered by schools, health clinics, and neighborhood-based agencies. They may also be offered in a more intensive format by family preservation workers who operate from services organized specifically to help families who are at risk of having children placed outside the home.

In offering supportive services to families, workers may interact with two or possibly more interlocking family systems: the focal family and the larger extended family of which the focal family is a part. The extended family may also include close family friends or neighbors who have a commitment to the focal family and are willing to provide various kinds of support. The relationship of each member of the triad: focal family, extended family, and family support worker, to one another is illustrated in Figure One.

- The *focal family* consists of the parent who initially approaches the family support services worker, her/his children, and any members of the household whom he/she considers to be members of the immediate family. This is the family group with whom the family support worker is most closely involved.
- The *extended family* consists of people whom the focal parent identifies as being part of her/his extended family system. It is defined by the parent and not by the family support worker. Extended family may include parents, grandparents, aunts, uncles, cousins, nieces, nephews, in-laws, and other, non related persons who are considered to function as extended family members.
- The *family support worker* is a professional or paraprofessional employee of a human service agency who offers such services as counseling, parent education, and referrals to families on a voluntary basis using a flexible, individualized, approach, with the goal of helping the focal family strengthen its functioning in areas identified by the family.

As Figure One illustrates, the key point in the triad is the focal family, whose members have relationships with both the family support worker and the extended family system. The family support worker, in an initial assessment, helps the focal family consider the extent to which extended family members may be a resource in helping them reach their identified goals. Depending on the situation, the focal family may wish the family support worker to meet directly with the extended family.

Figure one:
The Triad: Focal Family, Extended Family,
and Family Support Worker



Understanding Extended Family Relationships

As most family support workers know from their own experiences, family relationships are complex. Relatives may have complicated interactions with one another which are not well characterized by such labels as "positive" or "negative." Rather, relationships among family members who know one another well and have a long common history together tend to be multi-layered, with elements that may soothe, comfort, stimulate, and also irritate or frustrate those involved in them. In the face of these complexities, it is the task of the family support worker to assess the elements of extended family relationships, and to work with the family toward understanding the complexities and strengthening those elements which will promote better family functioning and the positive development of individuals in the family (Uehara, 1990; Norton, 1994).

Family relationships are not easily categorized. The two types of relationships described below are not intended to be exhaustive of all possible relationships, but rather have been selected because they are frequently encountered by family support workers. In each, both negative and positive elements are present. In the case examples used to illustrate these relationships, the family support workers assessed these elements, and developed intervention strategies to strengthen them.

- **Parenting pioneers** refers to focal families who have learned and begun to practice new child rearing strategies. Extended family members with traditional child rearing attitudes may find these new ways confusing or challenging. The focal family may seek help from the family support worker on how to negotiate the undermining comments and concerns of extended family members while maintaining positive family relationships.

- **Extended family parenting teams** refers to focal families who are giving to or receiving from extended family members substantial family support. The focal family may request help from the family support worker on how to strengthen the team, and how to access outside resources needed to maintain an adequate level of functioning. Extended family members may seek guidance on how to be supportive while maintaining appropriate boundaries with their needy relatives.

Parenting Pioneers

"Parenting pioneers" are parents who have learned and are committed to using the content typically taught in parent education classes, including:

- knowledge of child development and reasonable expectations of children at different ages and stages;
- understanding the meaning of children's behavior from a developmental perspective;

- child behavior management techniques other than physical punishment; and
- a view of the parent's role that encompasses "parent as child's first teacher" and resource broker for the child, as well as the traditional role of providing support, love, and physical care.

Parents who learn these techniques from family support workers may encounter resistance from extended family members concerned that these new methods seem counter to the traditional verities with which they raised children. For example, if a young mother, on doctor's or parent educator's advice, is feeding the infant on demand, her mother, who used a feeding schedule when her children were young, may believe that her grandchild will become "spoiled." The challenge in working with this category of family is to retain and build on the existing strength of the family system by reinforcing the parenting pioneer's efforts to try new approaches while retaining a genuinely inclusive and respectful attitude toward those who may be questioning these methods.

Examples of stress points between a parenting pioneer and extended family members on child rearing techniques include the following:

- **Discipline.** Differences of opinion on discipline techniques appropriate for children, such as alternatives to spanking and other physical punishment often cause conflict among family members. New techniques of child behavior management, such as time-outs, distracting, and ignoring, are strategies for reducing unwanted behaviors. Reinforcing good behavior involves praise and other rewards. These strategies may not be well understood by those unfamiliar with them. Parenting pioneers may hear such comments as, "You're bribing him for doing what he is supposed to do;" "You can't go by the book;" or "I spanked you and you turned out fine."
- **Spoiling.** Picking up babies when they cry, or frequent and prolonged holding and cuddling of the infant, may be seen as "spoiling."
- **Cultural Issues.** Parents who use new techniques learned outside the home may be accused of betraying their roots or culture. As one parent, who was trying to use alternatives to physical punishment, said, "They think that what I am doing is something that's white, or bourgeois middle class." This parent was able to deal with the issue by pointing out to family members that most white people also hit their kids.

Family Support Strategies

Those counseling parents who encounter resistance at home when trying out new parenting methods, can be effective if they avoid taking sides and focus on helping the parents develop skills in negotiating differences of opinion with family members. Parenting pioneers are usually well functioning individuals who probably received good parenting from their family of origin. Families of parenting pioneers usually have many strengths and are important resources for their children and grandchildren. It is important to try for an inclusive approach in helping the parent

resolve conflicts with extended family and not to get into a tug of war with extended family members for the allegiance of the parent, as the overall goal is to strengthen the parent's support system, and not alienate her from it.

- **Include extended family in the program.** Urge parents to invite the extended family member to come to parenting class or counseling session. Treat their contributions to the class respectfully. If you do not agree with what they are saying, it is often the best strategy to simply not comment on it, but to continue to emphasize the developmental needs of children of various ages. The logical implications of this child development information for parenting are often obvious. Another possibility is to arrange for the older adult to contribute their knowledge in some area, such as cooking, to the group.

Sometimes the mothers come with the pregnant teenagers to parenting classes. They are apt to sit in the back and say, 'I just drove my daughter; I didn't sign up for the class.' At first they are suspicious. They say, 'This isn't how I did it.' If they keep coming, they become willing to learn new ways. They share knowledge on how they raised their kids. It is better if grandma comes to class; she can reinforce at home what I taught in class. (A family support worker for pregnant women at a health clinic)

Provide handouts, videos and other material that the parents can take home and share with extended family members and friends.

- **Continually encourage the parents.** Reinforce and support the parents in their efforts to try new methods of child rearing in spite of discounting messages they may hear from relatives. Let them know that they are on-track, so that they don't get discouraged.
- **Role play responses to extended family members.** Role play with parents ways which they might use to respond to negative comments and concerns from extended family members. Help them find strategies that they are comfortable with.

I was counseling Annabelle on ways of helping her five year old son adjust to the demands of kindergarten. An only child, Mike was well behaved with adults but had difficulty relating to other children. The school rewarded the child with a star each day that his social behavior conformed to expectations. Annabelle then gave the child a reward, such as stopping at the store for a toy on the way home from school. Annabelle told me that her mother said, 'You should spank more often, you're bribing him.' Annabelle was frustrated and wanted support;

she needed to hear that she was doing the right thing. I met with her four or five times in individual counseling. We agreed that daily rewards were becoming excessive, and to change it to once a week - Annabelle would do something special on weekends if Mike had had a good week at school. This seemed to work.

To help Annabelle with her mother, I asked her, 'Do you feel comfortable spanking?' Annabelle said she did not and said that she had been spanked rarely as a child. Annabelle and I role played how she could explain her child rearing approach to her mother: 'I love you, but I want to try this new way. It is not bribing. It is encouraging Mike to learn a different kind of behavior.' (A family support worker in a neighborhood-based center)

- **Find allies in the extended family system.** Suggest that the parent seek out allies in the extended family network. One parent, who was receiving negative comments about her wish to breastfeed, discovered that her grandmother had breastfed her children, and was eager to coach and support her granddaughter in this effort.

Parenting pioneers are often leaders who have the potential to influence change in parenting among extended family systems and in communities. It is, therefore, particularly important to help these pioneers learn how to deflect resistance and work to change attitudes in their families without confronting or blaming family members for their parenting beliefs. As one parenting pioneer observed: "My mother does many things right and I have a lot to learn from her. I just need help in explaining to her why I want to try some new ways of doing things."

Extended Family Parenting Teams

The category of "parenting teams" is a broad one which encompasses many different specific situations. The unifying concept of this category is that the parent is living with the child and functioning adequately, but gives to or receives from the extended family system substantial support and help in child rearing.

As long as extended family members are successfully providing support adequate to one another's needs, outside family support may not be requested by the family. However, if the situation deteriorates due to some precipitating event, the family may call on outside help from a family support worker.

Assessment of Needs

The challenge of the family support worker is to adequately assess the situation and then creatively find resources in the community to keep the family support system intact so the children can remain safely with their parents, without the need for out-of-home care. Commonly encountered situations which may cause the family to seek outside assistance from a family support worker include the following:

- **Problems of the support provider.** Illness, marital problems, unemployment, or a housing crisis may hamper the ability of a family member to continue to offer needed support to another.
- **Problems of the support receiver.** A family member who was receiving significant support from the family may experience a deterioration in ability to function, and her/his neediness overwhelms the ability of other family members to provide adequate help.

In assessing these situations, the family support worker needs to consider:

- **Earlier functioning:** how well the mutual support system functioned before the precipitating event;
- **Needs of the support provider:** what services the extended family needs in order to provide increased support to the needy family member; and
- **Needs of the support receiver:** what services the lower functioning family member needs in order to improve functioning to supplement the ongoing support from extended family.

Family Support Strategies

The overall goal of the family support worker in working with parenting teams is to help stabilize and strengthen the family network so it can continue to function after the worker's involvement is reduced or ended. The family support worker enters the family system in order to work collaboratively with the family in deciding what needs to be done for the family to regain equilibrium and then helps them to achieve their goals. It is important for the family support worker to work with the family, and not to replace the family as an "expert" or be "better than" the family.

The following examples show two very different types of families. In one, two sisters are normally able to help one another, but a crisis for one sister, involving a sudden housing problem coupled with health issues of the children, temporarily derails the system of mutual help. The family support worker, by carefully assessing the strengths of the team, was able to offer practical help in a timely fashion while leaving the team stronger than it had been before the intervention.

Case example: Reciprocity among two sisters. I interviewed an 18 year old woman, Shirelle, who was home from college and was applying for ADC for herself and her one year old daughter. She also needed housing, because her sister, Marcelle, with whom she usually stayed when not at school, had lost her apartment and was in a shelter. We opened an ADC case for the sister and her three children, got Early On services for one child with special needs, and helped the family find housing. We also got a visiting nurse to help with one child's chronic kidney problems. The sisters are now living together in a decent apartment. This was a complicated case because the sisters were a support for one another, and to help one we had to help the other. (Family support worker in a public welfare setting.)

In this family, Shirelle depended on Marcelle for a home-base and for baby-sitting during summer vacations from college, while she worked. When Marcelle became overwhelmed with health and housing problems, Shirelle was concerned for her sister and also worried that she would not be able to return to college, but should stay home and help her sister. The family support worker respected the commitment these two sisters had for one another, and added more resources in the form of housing referrals and help with the developmental problems of Marcelle's children. Marcelle was then able to continue to support Shirelle in her efforts to obtain a college education.

The second case is an example of how family support workers can help extremely distressed families, whose needs have exceeded the capacity of concerned extended family members to help. By offering substantial help while remaining respectful of the extended family's previous efforts to intervene, the family support worker is able to stabilize the family so the children do not need to be placed out of home.

Case example: A mentally ill parent overburdens an extended family system. "Ms. Roberts came to me for help because the neighbors complained that her kids were molesting their children, and she was afraid that her kids would be taken away from her. She was on medication for a mental illness, bi-polar disorder. I thought she was functioning very well considering her illness. She regularly took her kids to school, went to day treatment, and then picked her kids up after school. Very soon after I met her, she was evicted from her house due to pressure on the landlord from the neighbors, and she moved to a shelter. I was able to help her find housing. The boys are now in treatment for sex abuse; they were acting out sexual abuse that they themselves had received earlier from a relative. She also goes to sex abuse therapy for herself, as she was abused by her husband. She is receiving parenting classes and in-home services to help her manage her time and keep a structured day.

I have also got permission from Mrs. Roberts to have contact with her mother and a cousin. The grandma had been heavily involved with this family but finally got overwhelmed and backed off. That's when I got the case. I was able to help grandma establish a role in the family that she is comfortable with. She provides back up day care if one of the boys is sick and can't go to school, and cooks dinner for the family once a week. She cares very much for

this family and wants to contribute, but she needs to know that we are also involved, and that she doesn't bear the whole responsibility. A male cousin who had been involved at an earlier time agreed to take the boys for an outing once a month, to provide them with a model of a positive male adult and to give them experiences which would expand their world. A close family friend, called Aunt Trina by Mrs. Roberts, volunteered to help the family get established in her church. This family needs ongoing agency involvement, but with the cooperation of professionals and the extended family, there is a good chance that the children will be able to remain with their mother. (A prevention worker in a child welfare agency).

The family support worker capably identified the strengths in this family system. Mrs. Roberts was a caring parent who was able to get her children to school and herself to treatment. She had relatives who were willing to offer support, but needed the worker's help in structuring their involvement so that they would not feel overwhelmed. The worker saw that these strengths, combined with outside resources, could help the family remain intact, in spite of Mrs. Roberts's serious mental illness and the acting out behavior of the children. She was able to provide resources without displacing or discounting the help provided by these relatives. With appropriate therapy and home support for the focal family, the relatives were able to fill the roles of supplemental parenting figures for the children. The work of the grandmother, the close friend, and the cousin contributed substantially to family stability and to the enhanced development of the children.

Summary and Conclusions

Family support workers are presented with many opportunities to work creatively with extended family members. Some examples of these opportunities have been presented here. The worker may be able to help "parenting pioneers" integrate new ways of child rearing into traditional family forms. If the grandmother is expected to have a major child rearing role, as is often the case with pregnant teenagers, then the family support worker may be able to teach her new techniques of infant care which will benefit the child. In situations involving "parenting teams," where extended family members help one another substantially, the family support worker may provide additional resources to the family needed for the extended family system to continue to function.

Whatever the situation, the family support worker is mindful of the following guidelines for working with extended family systems:

- Recognize that there is an extended family system with power to influence the service intervention, and that its role and potential must be assessed.

- Aim for an inclusive approach. Develop strategies for including the extended family in the intervention. These strategies may lead to direct involvement with the extended family or to indirect involvement, through the focal family. An important aspect of working inclusively is to help family members establish boundaries in their involvement in each other's lives that are understood and accepted by all.

- Establish your role as consultant and collaborator with the family, particularly in the area of finding and using appropriate outside resources and in facilitating family communication. It is counterproductive to insist upon one's expertise, which may embroil you in power struggles with family members who hold authority. Do not displace or compete with the existing family support system.

- Be prepared to help family members learn how to negotiate differences. Family support workers need communication and negotiation skills and should know how to teach these skills to families.

Family support programs have the potential to be important allies to community family preservation programs as the "first line of defense" in child protection. Important to the fulfillment of this potential is the development of practice skills among family support workers which will enable them to assess and intervene effectively in extended family systems.

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Conceptual Bases of the Planning Process in Family Preservation/Family Support State Plans

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Congress and the Department of Health and Human Services (DHHS) intend for the Family Preservation and Support Act of 1993 (P.L. 103-66) to catalyze major reforms in state human services systems. DHHS and numerous other institutions developed conceptual and procedural guidance for the states' planning processes. Review of the planning dimensions of participation and expertise reveals that major emphases on stakeholder participation and technical planning processes obscure the need for expertise in family preservation and family support.

The adequacy of the public child welfare system in many states has experienced increasing scrutiny during the past two decades. Initially, "foster care drift" was targeted. During the late 1970's, almost 500,000 children were living in foster care. Child advocates and Congressional investigation targeted patterns of organizational and institutional neglect of these children. The response to these revelations was the development of a set of practice and procedural innovations called Permanency Planning. This movement focused the attention of child welfare systems on providing parents of children in foster care with clear choices and time frames in which to act to be unified with their children. As a result, foster care placement rates declined. Subsequently, the Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) established states' obligation to "make reasonable efforts" to maintain at-risk children in their own homes and required judicial determination that the efforts had been made (McGowan, 1988, pp. 69-89).

By 1986, the brief decline was over and placements began to rise anew. As we moved into the next decade, three-fourths of the states continued to experience growth in the number of children in foster care by 5-10% per year (Tatara, 1993). An associated dilemma was the sheer volume of child abuse and neglect reports. "In the context of rising caseloads and declining resources, 'business as usual' is no longer possible and agencies are turning to family preservation and family support to address increasingly complex needs" (Nelson & Allen, 1995, p. 109).

Since the 1970's, there has been an accelerating interplay between practice innovation and federal and state attempts to improve services in the child and family arenas. At the federal level, this process culminated in the passage of the Family Preservation and Support provisions of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66). The Act makes available to states one billion dollars over five years (Lloyd & Sallee, 1994, p. 4). One of the significant features of the Act is that it has initiated a broad-based experiment in near textbook social planning.

This paper describes the process by which planning and implementation of the Family Preservation and Family Support Act were initiated. The federally established process is analyzed in light of Gilbert and Specht's analysis of the community planning processes within the context of social welfare. Three competing values emerge in the social planning arena. These prized values are participation, expertise, and leadership (Gilbert & Specht, 1969, pp. 338-345). Analysis of the interplay among these critical values provides a useful framework for ongoing study of the process by which the Family Preservation and Support Act is implemented. Examples are drawn from review of the state plans developed in federal DHHS Region VI, as well as composite data from a national study commissioned by the Administration for Children and Families, DHHS. This analysis suggests areas of emphasis and further study as the implementation of the Family Preservation and Support Act continues.

The program instructions developed by the Administration for Children and Families, Department of Health & Human Services, provide the following direction:

The legislation requires states to engage in a comprehensive planning process [emphasis added] for the development of a meaningful and responsive family support and family preservation strategy. To take full advantage of the opportunity for comprehensive planning, the scope of planning should go beyond child welfare to include housing, mental health, primary health, education, juvenile justice, community-based programs providing family support and family preservation services, and other social programs that serve children and families in the state and its communities. Consumers, practitioners, researchers, foundations, mayors, and legislators are some of the stakeholders who should be active in the planning process (USDHHS, 1994, p. 1).

The program instruction laid out the broad goals and provided working definitions for family preservation and support services and a list of six "shared principles most often identified by practitioners." It neither required nor endorsed any specific program model for implementation. In fact, other than appending a number of individual program models, the program instructions offered little guidance for the full system and cross-system structural innovations and designs by which the envisioned family preservation and support strategies could be implemented. However, states would have an opportunity to discuss the bases for the selection of their program models, the operation of specific service designs and options, and sources for additional information on high quality program approaches and models. The shared principles include that services are focused on the family as a whole, are easily accessible, are flexible and responsive to real needs, are community-based and involve community organizations and residents (including parents) in their design and delivery.

The federal guidance further urges states to "seize the extraordinary planning opportunity by engaging in a thoughtful, strategic planning process [emphasis added] that includes a wide array of state, local and community agencies and institutions, parents, consumers, and other interested

individuals" (USDHHS, 1994, pp. 10-12). Finally, the state planners are advised that state planning and service development activities should include the identification and gathering of data needed for planning (USDHHS, 1994, p. 12). They were encouraged to use 100 percent of the first year funds for "comprehensive planning and other planning related activities such as training, technical assistance, assessment, public education, and commissioning further analyses" (USDHHS, 1994, p. 21).

The magnitude and importance of this planning process is illustrated by the extensive roster of national organizations which involved themselves in the development of planning tools and the provision of technical assistance for state planners. Of particular note was the collaboration of the prestigious Center for the Study of Social Policy and the Children's Defense Fund on a 150 page planning guide entitled Making Strategic Use of the Family Preservation and Support Service Program and the Family Impact Seminar's collaboration with numerous national experts to provide An Assessment Tool for the Child and Family Service Plan. Various other planning supports were developed by the network of resource centers funded by the Children's Bureau, DHHS. Despite the fact that the state agency administering the public child welfare program was most frequently designated as the lead agency for the planning process, little representation from these state agencies was included in the process of developing tools and planning supports.

The Administration for Children and Families, DHHS, contracted with James Bell Associates to conduct the "Family Preservation and Family Support Services (FP/FS) Implementation Study." There was a preliminary report issued in 1995 and the "Final Report on Analysis of 1995 Five-Year State Plans," which was issued in March of 1996.

Participation

According to Gilbert & Specht, the first planning value is participation. A salient feature of the guidelines for the planning process initiated by the Act is the constant emphasis on actively involving a broad-based group. The program instructions list nine required categories of stakeholders including parents, community representatives, judges, advocates, and public and private service providers, from the major human service systems (USDHHS, 1994, p. 50668). A reviewer of the planning tools is immediately struck by the frequency of words from the rhetoric of participation such as "inclusive," "broad-based," "stakeholders," and "community." While the majority of the planning processes are conceived and administered from the state level, this emphasis on the community's role and the involvement of parents is a clear departure from other recent planning endeavors in the arena of services to children and families. The preliminary Bell Associates Report indicated that most states appeared to make serious efforts to be as inclusive as possible in the planning process.

The value of participation is supported by experiments which indicate that when people are engaged directly in the decisions that impinge on their own lives, those decisions are more likely to be binding. However, by opening the planning process to many stakeholders, "a swarm of

competing claims to the public interest descend and decision-making is at risk of degenerating into a hopeless drone of discussion and debate" (Gilbert & Specht, 1969, pp. 338-345).

Let us consider first the most important grassroots participants, the parents and families who receive family preservation and support services. Over 80 percent of the states reported parent involvement at the outset of the planning process (Bell Associates, 1995). Several regional DHHS offices noted that the level of consumer involvement diminished during the course of the planning effort. These dynamics are characteristic of the level of citizen participation at which citizens begin to have some real degree of influence. However, the effectiveness of their efforts and how long their participation is maintained largely depend on the quality of the technical assistance they have in articulating their priorities and the extent to which they are organized (Arnstein, 1969). It is legitimate to conclude that what rescues participatory efforts from being perceived as placation and what sustains consumer participation in the planning process is provision of the expertise needed to meaningfully participate. In the national study, only the state of Maryland is noted as supporting this process by conducting leadership training for parents who participate in the planning process (Bell Associates, 1996).

The second major group of stakeholders is the professionals in the human services arena. The Bell Associates Preliminary Report indicates that involvement of private welfare agencies, advocacy groups, and other community-based organizations was reported in from 72 to 78 percent of the state plans analyzed (Bell Associates, 1995, p. 54).

Expertise

A potential antidote to the dilemmas introduced by multiple stakeholders is combining participation with a high level of expertise. This concept includes "the special skills and knowledge possessed by the planner" (Gilbert & Specht, 1969, pp. 344-45). In addition, this second value has more than one dimension. The first dimension is the value of knowledge and skill about how to plan, in which the planner is accountable primarily to the requirements of his profession. This conception may overlook the importance of the second dimension, which is expertise in the arenas of human activity in which a discrete planning endeavor is focused, in this case the principles and practice strategies of family preservation and support. These include the program designs, service innovations, and collaborative strategies which have potential to carry the benefits of this approach cross-systems to all human services. The question which rises is to what extent are planning processes enlightened and guided by both types of expertise? Federal program instruction and planning tools emphasize community and grass roots participation and application of the technical expertise of strategic planning. The values base and expertise of family preservation and support, accumulated over the past 20 years, while evident, are given much less emphasis. Even when guidelines urge steps to ensure that stakeholders are actively engaged in planning and "have all of the information and support they need to be full participants" (Allen, Emig & Farrow, 1994, p. 107), the content that is recommended is "of administrative, budgeting, and other issues," rather than interpretations of

program information and research data presented in ways to engage and galvanize them to advocacy.

Leadership

The third value is leadership in which the planners either make complex decisions or align with powerful leaders who have the authority and skill to implement. The caveat for implementing a paradigm shift as value laden as that of family preservation/support is that leaders (administrators and planners) who set the direction and make the salient decisions about service system orientation often are political appointees whose selection may have little relationship to their planning expertise, service orientation, or value set. Ideally, they would look to the planner for the needed expertise and, ideally, the planner is expert both at planning and at the special knowledge of family preservation and family support. Even when an administration's value sets are congruent with the new paradigm, "the capacity to rule or lead does not ensure the capacity to plan and implement changes" (Gilbert & Specht, 1974, p. 346).

Interplay of Values

As the direction was set for the nation to plan and implement the Family Preservation and Support Act, this planning effort seemed to support the Gilbert & Specht observation that "... at their inception all community planning programs seem to invoke all three values, though this kind of tout ensemble never comes off very well. One of the values is sooner or later elevated above the rest" (Gilbert & Specht, 1974, p. 347). The remainder of this paper reviews the interplay of the values of participation, expertise, and leadership during the planning year phase. The hypothesis is that, while the Act and federal program instruction enabled a blend of all three, in practice, an emphasis on grass roots participation and the expertise of strategic planning methods often emerged above the values of informed leadership and the practice expertise of family preservation and family support.

We choose to follow Rothman and to use Friedman and Hudson's definition of planning as "an activity centrally concerned with the linkage between knowledge and organized action" (Rothman, 1995, p. 290) [emphasis in the original]. It then becomes a logical progression to look at the levels of knowledge and expertise which support the players at each stage of the planning process.

The national state plan analysis notes that first year training and technical assistance were focused on assisting with planning process activities. Those activities specifically mentioned were needs assessments, focus groups, parental involvement, gathering baseline data, and priority setting (Bell Associates, 1996, p. 61). Significantly, training in the second dimension, which is the specialized expertise of family preservation and family-centered practice, largely seems missing from the first year planning process. An alternative interpretation is that data was not collected on the training dimension of planning. Indeed, the Report concludes that "less

information was available in the state plans concerning training and technical assistance efforts to support FP/FS service delivery" (Bell Associates, 1996, p. 62).

The preliminary Bell Associates Study breaks out the percentages of first year planning allocations which states designated for training and technical assistance. Thirty-one states reported no allocation in this category during the planning year, although, in some instances, funds spent for training may be included in the general planning allocation category (Bell Associates, 1995).

In recent years, critics of professional education and training have called into question the competency-based approach to training precisely because it is grounded in analysis of what is currently being done. If family preservation is characterized accurately as a genuine paradigm-shift, it requires methods of training which provoke, inspire, and catalyze cognitive restructuring and a new set of practice competencies.

This is particularly true when the envisioned change requires participation and collaboration among multiple largely independent systems. The planning guides repeatedly urge planners to involve all major human services systems. "... Change must occur at the policy, administrative, and service levels of all agencies, serving children and families" (Allen, Emig & Farrow, 1994, p. 13). This implies that the intent is to apply the values, strategies, and techniques of family preservation and family support throughout the human services system. Systems frequently mentioned include health, juvenile justice, mental health, and developmental disabilities services. Applying the paradigm shift across systems requires major changes in the values, attitudes, and behavior of members of each system.

Another tenet of family preservation practice, family empowerment, also supports a stronger role for pre-planning training. Classic empowerment theory declares that being aware of and possessing the knowledge and skills to implement potentially better options is a prerequisite to genuine empowerment. Are local stakeholders, whether consumers or agency leaders, empowered to plan if they have never been introduced to the values nor mastered the state-of-the-art strategies and designs which accompany the paradigm shift?

The need for training in the innovative designs and techniques of family-centered practice may be equally strong among professionals from disciplines or agencies in which traditional practice does not include or support the principles of family preservation practice. Developing expertise and options through excellent training may be the most accessible route to integrated community planning, yet cross-systems training is barely touched upon in the planning tools and guidelines to implement the Act.

In fact, there are precedents in accomplishing this feat at the state level. Faced with narrowly categorical and fragmented services, complex bureaucracies, and declining resources, several

states are now turning to family centered services as the cornerstone by which to integrate human service systems (Adams & Allen, 1995, p. 109).

Contrast the suggested planning process with the process employed by Idaho, one of the acknowledged national leaders in system-wide innovation. Extensive training and consultation from the National Resource Center on Family Centered Practice included two weeks of training for each system's management and supervisory staff and 50 hours for direct service and supervisory field staff.

It is especially noteworthy that all this training preceded the state's planning for administrative and rules changes. It was felt that only after staff had developed substantive knowledge and skills through training, could their experience be incorporated into policy development (Nelson & Allen, 1995, pp. 118-119). In summary, training at the community level has the potential of strengthening and focusing administrators' potential as system change agents, laying consensual groundwork for effective coordination between and among agencies and disciplines, and enlivening the participation of all stakeholders in the planning process.

From the review of Region VI plans, three types of expertise emerged as important to planners and stakeholders: (1) pre-planning inspiration and education of planners and stakeholders on the basic practice and program design principles of family preservation and family support; (2) technical methodologies for measuring need and allocating resources; and (3) the technology of outcome-focused goal setting measures and monitoring. The plans also reveal that who plans is a relative matter that depends upon the organizational arrangements among planners, political, and state agency leaders.

Lead state agencies have responded to the importance of the strategic planning process as demonstrated by how they accessed planning expertise. For example, Oklahoma contracted with the National Resource Center for Youth Services, located in Tulsa, "to collaborate and manage the planning process, including the design and implementation of the needs assessment process" (Oklahoma Department of Human Services, 1995, p. 3).

Oklahoma was the only Region VI state in which systematic pre-planning training was a reported component of the planning process. It is reasonable to conclude that the fact that that planning agency (National Resource Center on Youth Services) is noted for the quality of the training materials it develops and the training it delivers, predisposed their awareness of the potential importance of pre-planning training. A series of eleven three hour information sessions were held throughout the state to prepare for the planning effort.

Louisiana engaged staff from the National Resource Center for Management & Administration in Human Services at the University of Maine. The Resource Center collected as much information on each parish as was available. The information was compiled and used as background data for community forums, as well as being incorporated into a set of databases

which allowed for detailed comparative analyses of the parishes. Eight indices were created and integrated into a single child and family need index. Total index scores were used to scientifically determine the ten parishes in which the systems of family preservation/family support service will be developed and expanded (Louisiana Department of Social Services, 1995, pp. 18-27).

Again, we point out that the type of expertise which leaders chose to engage profoundly shaped the planning process and outcomes. The resource center known for its technical expertise in management information systems and data analysis assisted the state to develop a sophisticated methodology to bring together need and resources. In this instance, the high quality of technical expertise available to the assessment process provided a solid database on which the participatory forums could function.

Federal guidance and the planning manuals previously referenced all stress "community" participation. For example, Texas held 27 consultative town meetings (Texas Department of Protective and Regulatory Services, 1995, p. 20). Oklahoma received input from community members and service providers in telephone surveys, in community meetings, and in focus groups (Oklahoma DHS, 1995, pp. 9-12).

The extensive emphasis on "community participation" requires further clarification of the actual role in plan development for the nine designated categories of stakeholders. In the current planning effort, the term "community" is used with almost mystical connotation of value. Yet many assert that geographical sense of community is all but extinct (Panzetta, 1972, p. 28). Is it perhaps anachronistic to program for a form of social organization that many assert no longer exists? Furthermore, it is uncertain that "community interest" is accurately represented by often self-selected or "professional" consumer members of an essentially horizontal "community" such as clients of the child welfare or other human service systems? This dilemma may be resolved by clarifying whether the community representatives are "facilitative" decision-makers or whether their role is one of sensitizing the decision makers to representative client family perspectives. The sensitizing role seemed to be the one operant in the plans reviewed. In either case, their ongoing participation is critical.

In addition to broad-based participation, a second theme of planning instructions and Vice President Gore's National Performance Review seems to be understood and heeded. The slogan "moving from red tape to results" requires a shift from measures of program activity to results measured as outputs and outcomes (Cohen & Ooms, 1994, p. 13). The Region VI plans demonstrate this movement by including largely appropriate process indicators and outcome measures. While the ultimate attainability of some (i.e., reduction in the divorce rate) or the utility of others may be unclear, they nonetheless represent a clear intent on the part of leadership to demonstrate results with measurable outcomes.

The effects of three major planning values are evident in the plans developed to implement the Family Preservation and Support Act. However, as we seek to improve the effectiveness of actions in pursuit of valued outcomes, as systems boundaries get stretched and as we become more sophisticated about the complex workings of open societal systems, it becomes even more difficult to make the planning idea operational" (Gilbert & Specht, 1977, p. 33). Developing the undeveloped facets of a cross-systems approach requires innovative application of each of the three of the planning values reviewed in this paper. Expertise on such issues as development of instruments and curricula for cross-systems application, caseload management, and implementation of funding strategies for managed care are current needs. All require a much greater role for development of expertise through training and technical assistance. The realization of the lofty visions of each state plan will be shaped by how dialectically responsive the leadership of each system can be to the emerging needs for expertise, leadership, and participation.

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Current Resources

The Book of David: How Preserving Families Can Cost Children's Lives. Richard J. Gelles. New York: Basic Books.

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Richard Gelles has written an important book that, like the child welfare programs and systems he reviews, has a bright side and a dark side. By focusing on the life and death of one child (named David) known to the child welfare system, Gelles illustrates, in very clear fashion, the shortcomings of the present delivery of services to prevent and treat child abuse and neglect. One of Gelles' main criticisms of the public child welfare system, with family preservation at its center, is that it has faltered in the hands of zealots making overblown claims. The subtitle of Gelles' own book, "*How Preserving Families Can Cost Children's Lives*," seems to evidence the same flaw, however. Gelles proposes a fairly zealous revamping of the child welfare system himself, with child deaths and severe abuse as the sensationalist springboard for many of his recommendations.

Gelles' book is a brief little analysis of the public child welfare system, and accomplishes a great deal toward educating the public in clear, understandable language about the structure and components of the current system and the inherent obstacles to the prevention and treatment of child abuse and neglect. There is much to be lauded here. Chapter One is an excellent discussion of how statistics can be sensationalized, and how some media and scholarly coverage of the well-being of children and families along sensational lines (satanic cults, sexual abuse in day care) detracts attention from more generic and pervasive risks and harms to children. Chapter Two is also a balanced discussion of reporting laws for child abuse, and the conclusion that mandated reporting can contribute to both under reporting and over reporting. This chapter is propitious in exemplifying the complexity of the system and its mandates, and the reality that the arguments and outcomes in this field are not "either/or," but systemic and multi-determined.

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The views expressed in this article are those of the writer, and they do not necessarily represent those of the agencies referenced or the United States Government.

Beginning in Chapters Three and Four, with a discussion of risk assessment and the provision of reasonable efforts to preserve and reunite families, Gelles begins to present his critical analysis in more specific terms. Gelles proposes the inclusion of Prochaska and DiClementi's (1982) Stages of Change in the assessment of parents' willingness to engage in treatment, and that the system move quickly to termination with parents who are not in a stage of change-readiness.

Finally, in Chapters Five and Six, Gelles discusses "the failure of family preservation" and proposes a more child-centered system (which includes more expeditious termination of parental rights and increased usage of foster care and adoption). These arguments and analyses are based, again, on the documented failures of the current child welfare system in preventing severe abuse and child deaths. Gelles reviews the research on family preservation in the briefest of discussions, and draws many general conclusions about family preservation (often failing to distinguish between family preservation as a program model and family preservation as a service goal) from a variety of studies which are quite incomparable. Specifically, the book's review of the actual research base for family preservation programs comprises less than two pages of Chapter Five, citing four references (pp. 126-127).

Gelles states that family preservation services cannot work because child welfare workers and administrators "have an unrealistic belief in their own effectiveness (pg. 142)." This is quite simplistic. Child welfare workers and administrators attempting to make sound decisions and design and implement reasonable efforts to preserve families are making those assessments and decisions on more than "unrealistic beliefs." They utilize the technology of risk assessment, the amount of training they are given, the resources available to their program, etc. These are not uninformed zealots, as Gelles would have his readers believe. Clearly, the system can benefit from enhanced compensation for skilled workers, improved training, continuing development in assessment technology, and critical thinking and design of relevant service plans and goals with families. This does not imply that we abandon hope that families can benefit from services, however.

These final chapters are where the flaws of Gelles' argument surface, and where Gelles becomes a party to his own criticism of the sensationalism of the discussion. Child deaths are a fairly unpredictable and rare event, but are indeed sensationalized, and framing services around the heightened attention given severe abuse and child deaths neglects the more pervasive issues of poverty, poor parenting, community dissolution, and so on. Gelles gives these issues short shrift in his final recommendations for system overhaul. Finally, the call for a narrowed focus on severely abused children, during the current political climate of thinning the economic safety net for all families, is dangerous.

Overall, this book is very important and illuminating. It is well written, clearly presented, and discusses many important components and controversies of the current child welfare system. It is critical reading for anyone involved in child welfare, and will provide fodder for the public debate for months and years to come. It is important, however, that it be read with a critical eye.

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Children in Families at Risk: Maintaining the Connections. Edited by Lee Combrinck-Graham. New York: The Guilford Press.

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Children in Families at Risk: Maintaining the Connections is an edited collection of 17 chapters that present programs or interventions described as exceptional in that they go against the experts' tendency for over-reliance on separation of family members as a resolution to family difficulties at the expense of families' yearning for connectedness.

The book is organized into six sections--changing the way we think about engaging families, family preservation, families of children placed in institutions, foster care options, reunification, and connecting programs. Each chapter includes a discussion of the theoretical framework, philosophic underpinnings, or assumptions on which the program is based. Each contains a description of the program or intervention, emphasizing structural aspects of the program, stages or processes of an intervention, or clinical concepts and treatment techniques. Each chapter is replete with case examples, sometimes presented in separate sections and sometimes interwoven with theory or program description. Discussion of evaluation is minimal, and summarizing statements range from perfunctory recaps to insightful distillations of the contribution of the chapter.

The programs presented in this book are theory based, though the strength of the theoretical presentations varies considerable from chapter to chapter. In several instances, theory is explicit and detailed. In others it is referenced or left to be inferred from case discussions. Family therapy, in its various forms, provides the conceptual material for most of the programs. The use of construct theory is also apparent. Social construct theory provides a rich context for discussion of work with inner city tribes; personal construct perspectives, blending truths, and eliciting family stories. Attachment theory supports programs' understanding of maternal/child bonds and of ongoing family ties. Last, the ecological perspective is apparent throughout the chapters and is explicitly referenced in several.

Themes of the book center around how practitioners think about and relate to families. Throughout the book we are reminded to approach families with humility, since we are guests, intruders in their space. A second theme is respect for the family as an important source of information about itself; practitioners are to approach families with curiosity about their life stories, about how families experience themselves and their world. A third theme is that families have considerable strength and competence that are often not fully recognized. Last, the book stretches our concepts of family inclusion, demonstrating its implementation in a variety of settings.

This book has many strengths. The theoretical discussions and their clear application to practice with at-risk populations are very helpful. The rich clinical material infused throughout speaks to the quality of the programs included. In addition, the repetition of the themes in various contexts and in various ways gives a voice to families, who are needing and wanting to be respected and heard. Like any edited work, some chapters are richer than others. There are admitted difficulties in terms of evaluation. The chapters provide many examples of good case outcomes, and this evidence of quality is not to be ignored. However, the reader will not find much reference to systematic outcome studies. The most detailed reporting of quantitative outcomes is in relation to a family preservation program, not surprising since such programs have been popularized on the basis of cost savings related to fewer out-of-home placements or fewer days in care. Several chapters address the difficulty of evaluation, and one makes the case for good formative evaluation so that evaluation and program interact through an iterative process and program can continue to self-correct.

Practitioners and educators alike--anyone concerned about at-risk children and families--will find this book valuable. Though the programs are described as exceptional, the values, attitudes, and knowledge on which they are based should be commonplace, should be central to all child and family practice. That this is not currently a reality provides one of our greatest teaching and practice challenges.

Family-Centered Behavior Scale and User's Manual. Reva I. Allen, Christopher G. Petr, & Beverly F. Cay Brown. The University of Kansas.

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"Family centered" has become a standard descriptor for human service programs across the continuum of service delivery systems, as agencies strive to promote the best available practices and to follow the mandates of public policy. The degree to which any program, agency, or interagency collaborative is truly family-centered in its practices, however, has not been subject to serious methodological scrutiny. We have been willing, more or less, to accept a declaration of family-centeredness at face value. With an ever increasing emphasis on proving one's worth and documenting results, programs must now find methods to demonstrate (among other things) their family-centeredness.

The Beach Center on Families and Disability, a research and training center at the University of Kansas which focuses on families who have a member who is disabled, offers the Family-Centered Behavior Scale as a tool for agencies to use in evaluating the family-centeredness of their programs. The Scale is a twenty-six item scale of professional behaviors that are believed to demonstrate family-centered practice. The scale items were derived from an extensive review of the literature and presented for discussion in a series of focus groups; the resulting instrument was field tested with a small pilot group and formally tested through a large national survey.

In administering the scale, consumers are asked to complete the rating scale with reference to one staff person, defined by the program. A companion scale, the Family-Centered Behavior Scale-Importance, may be used to query respondents on the value that they attribute to each of the rated behaviors. The two scales can then be compared by computing a discrepancy score for each item: the difference between how important the behavior is to the respondent and the degree to which the staff person practices this behavior. Mean scores on each item as well as a total mean of all items across all respondents, provide a measure of the degree of family-centeredness of the program.

The Family-Centered Behavior Scale brings a number of strengths to the field. First, by offering a systematic method of evaluating family-centered practices, this scale begins to fill an existing void in the field. Second, the scale can be administered with minimal resources--basically, the cost of the manual, duplication of the scales, the postage and supplies needed to conduct a survey, and a limited amount of personnel time. Third, the User's Manual accompanying the scale is clearly written and easy to understand, particularly for those without formal education in research methods and statistics. It offers practical advice on administering the scale, such as suggested sampling procedures, a sample cover letter to accompany the survey, supplemental questions that might be added for additional analysis, and ideas for conducting pre and post tests. The scales are easy to score and to interpret, and the reliability, both test-retest and internal consistency, appears to be very good.

Finally, the authors took special efforts to enhance the cultural relevance of the scale by translating it into Spanish, and submitting it for review to several people with Spanish as their primary language. By so doing, input from Spanish speaking consumers can be systematically included in an organization's assessment. In the survey that served as the basis for the scale's results, geographic and racial/ethnic diversity were achieved, with responses received from 45 states and 27% from minority populations.

As with all scales (and especially new ones that have not had the advantage of time for more extensive testing), certain factors should be considered in using the Family-Centered Behavior Scale. First, analysis of results was performed based on 443 usable surveys out of 1700 that were distributed. Results from any survey with a usable rate of 26% must be interpreted cautiously, as we do not know the nature or extent of selection bias that might have been introduced. Second, as a project of the Beach Center on Families and Disability, the Family-Centered Behavior Scale was tested with a population of caretakers of children with a disability. Respondents came largely from two-parent households (72%) with incomes averaging \$35,000 annually. Whether the scale will prove to be equally reliable and valid with primarily low-income populations such as families served by child welfare agencies, remains to be tested.

Another limitation is the difficulty in distinguishing the measurement of family-centered behaviors from the respondent's general disposition toward the staff member. In testing the instrument, moderate to strong correlations were found between scale items and overall satisfaction with the staff member, and the authors also report that the scale items significantly differentiated responses between those who were asked to describe their best and worst staff member. In the absence of other sources of data which could be used to cross-validate consumers' ratings of staff behaviors (i.e., staff self-reports of their practices, observations of staff/consumer interactions, empirical data from case records, etc.), this question currently remains unanswered.

An interesting issue generated by the Family-Centered Behavior Scale is whether an organization's, or program's, family-centeredness can be measured as a function of the average

frequency of specific practices of its individual employees. One can argue that from the perspective of consumers, an agency's family-centeredness is experienced through a relationship with a staff member. Extending that principle, by aggregating the experiences of many consumers, the mean score may be a reasonable estimate of the agency's family-centeredness. From another point of view, an organization's family-centeredness may be more than an average of the behaviors of direct service employees, involving staff at all levels from direct service through top administration, embedded in agency policies and procedures, and evidenced in broader activity within the community rather than solely in traditional one on one staff/client relationships. The authors of this scale would likely take the broader view, presenting the Family-Centered Behavior Scale as one part of a larger organizational assessment process. With such a perspective, this tool may make a significant contribution to the understanding of family-centered practices from the consumer's point of view.



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