A PROGRAM EVALUATION OF A HOME VISITATION PROGRAM: USING FLOORTIME TO ENHANCE POSITIVE PARENT-CHILD INTERACTIONS IN AT-RISK FAMILIES WITH OPEN CHILD WELFARE SERVICES CASES

Denise I. Tillery
B.A., California State University, Sacramento, 2007

PROJECT

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SOCIAL WORK

at

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

SPRING
2009
A PROGRAM EVALUATION OF A HOME VISITATION PROGRAM: USING FLOORTIME TO ENHANCE POSITIVE PARENT-CHILD INTERACTIONS IN AT-RISK FAMILIES WITH OPEN CHILD WELFARE SERVICES CASES

A Project

by

Denise I. Tillery

Approved by:

[Name redacted], Committee Chair

Susan Taylor, PhD, MSW

4/17/05

Date
Student: Denise I. Tillery

I certify that this student has met the requirements for format contained in the University format manual, and that this project is suitable for shelving in the Library and credit is to be awarded for the Project.

[Signature]

Susan Talamantes Esguerra, PhD, MSW
Graduate Coordinator

4-20-09
Date

Division of Social Work
Abstract

of

A PROGRAM EVALUATION OF A HOME VISITATION PROGRAM: USING FLOORTIME TO ENHANCE POSITIVE PARENT-CHILD INTERACTIONS IN AT-RISK FAMILIES WITH OPEN CHILD WELFARE SERVICES CASES

by

Denise I. Tillery

Child maltreatment and subsequent family involvement with Child Welfare Services exacts a high toll on children, families, communities, societies, and even on future generations. Maltreated children are at higher risk for developing insecure attachment styles as well as a plethora of maladaptive behaviors. Costs upon all are high; therefore, effective service programs are needed to enhance parental knowledge, attitudes, and skills and to improve parent-child attachments. This qualitative program evaluation examines the effectiveness of a home visitation program to improve parenting practices among at-risk families who have open Child Welfare cases. Using a mind-mapping technique (Buzan, 2008), preliminary results indicate that instructing parents in the floortime model can elicit more nurturing parenting practices.

Susan Taylor, PhD, MSW

Date
DEDICATION

This volume is dedicated to all who have helped me on my journey to this moment in my life. First, my love and gratitude go to my husband, Larry, who encouraged me to fulfill my dreams, provided his constant support and love, picked up the slack in many ways, listened without judgment, and was often my inspiration. I am also grateful to my children, Medina, Michelle and Vidal, Stephen, and Philip and Jennifer, and my grandchildren, Victoria and Vidal, III. All of you have contributed in vital ways to the development of the person I am today and to the work in these pages. You bring joy and light to my life. Acknowledgement goes to my parents, Dennis and Isabella, for instilling in me love, persistence, a strong work ethic, and the value of education. You taught me to always keep my word and do my best. I also thank the many other family members and friends whose ever-present encouragement and support has sustained me throughout the years. Thanks to all of you for growing alongside me.
ACKNOWLEDGMENTS

I want to thank CommuniCare Health Centers for allowing me to review and evaluate the Family Life Skills Home Visitation Program for my Master's of Social Work project. I appreciate the consistent support and encouragement from everyone at CommuniCare. I am especially thankful to Tina Lilliedoll and for bringing me on board with my first year internship and to Christina Andrade-Lemus for providing great backup supervision. I am thankful to Karen Larsen and Cathy Sutton for bringing me back for my second year internship. Working in Integrated Behavioral Health Services has been a very rich experience.

There are two people to whom I am especially grateful, my Family Life Supervisor, Sue Lomax, and my MSW project advisor, Dr. Susan Taylor. Thank you for helping me shift my project when it was necessary, for believing in me, encouraging me, and for being such wonderful human beings. Finally, I want to acknowledge Pastor Ken Bluemel whose explanation of how trust is developed in children became foundational for the development of the graphic illustration of the Development of Secure Attachments in Children as depicted in Figure 1.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Dedication</th>
<th>vi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgments</td>
<td>vii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>xi</td>
</tr>
<tr>
<td>Chapter</td>
<td></td>
</tr>
<tr>
<td><strong>1. INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td>Background of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>3</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>3</td>
</tr>
<tr>
<td>Personal Interest in the Problem</td>
<td>4</td>
</tr>
<tr>
<td>Theoretical Frameworks</td>
<td>5</td>
</tr>
<tr>
<td>Research Question</td>
<td>7</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>7</td>
</tr>
<tr>
<td>Justification for the Research Project</td>
<td>9</td>
</tr>
<tr>
<td>Limits of the Project</td>
<td>10</td>
</tr>
<tr>
<td>Summary</td>
<td>10</td>
</tr>
<tr>
<td><strong>2. REVIEW OF THE LITERATURE</strong></td>
<td>12</td>
</tr>
<tr>
<td>Introduction</td>
<td>12</td>
</tr>
<tr>
<td>Attachment Systems</td>
<td>13</td>
</tr>
<tr>
<td>The Development of Attachment</td>
<td>14</td>
</tr>
</tbody>
</table>
5. DISCUSSION .................................. 65
   Introduction .................................. 65
   Discussion of Findings ......................... 65
   Implications of the Findings ..................... 69
   Limitations of the Study ......................... 71
   Recommendations for FLS Improvement ............ 71
   Implications for Social Work Practice ............ 74
References ....................................... 76
LIST OF FIGURES

1. Figure 1. Development of secure attachment in childhood..............................14
2. Figure 2. History of substance abuse among caregivers ...............................45
3. Figure 3. Participants identified with mental health disorders.......................46
4. Figure 4. Legal problems of caregivers......................................................47
5. Figure 5. Report of limited caregiver social support......................................47
6. Figure 6. Reports of family violence among program participants.....................48
7. Figure 7. Top three CWS concerns about caregivers and children....................49
8. Figure 8. Responses to key items on the Intent to Participate..........................50
9. Figure 9. Caregiver expectations................................................................52
10. Figure 10. Caregiver empathic awareness....................................................54
11. Figure 11. Disciplinary styles......................................................................56
12. Figure 12. Caregiver beliefs about children’s power and independence ..........59
Chapter 1

INTRODUCTION

In 2006, approximately 3.3 million reports of child maltreatment across the United States were filed with and investigated by Child Welfare Services (CWS) (U.S. Department of Health and Human Services [DHHS], 2008). Of the alleged maltreatment of over 6 million children nationwide, CWS substantiated 905,000 allegations (DHHS, 2008, p. 25). Almost 12 percent of those (107,524) occurred in the state of California (Needell, et al., 2009). Most concerning is that children under a year old had the highest rates of maltreatment and recidivism than all other age groups. Furthermore, the vast majority of alleged perpetrators (82.4 percent) were parents (DHHS, 2008, p. 30).

Although substantiated cases of child maltreatment have decreased over the past few years, there is a major problem when a society’s most vulnerable persons are harmed by those whose job it is to nurture and protect them. Moreover, when a child is harmed or improperly care for, the effects of dysfunction, maltreatment, and violence may ripple across one generation after another.

Background of the Problem

The Child Welfare system encompasses a group of service providers whose job it is to ensure the safety, health, and well-being of children by providing permanency planning and support in strengthening at-risk families (Child Welfare Information Gateway [CWIG], 2008). Collaborative efforts between public and private Child Welfare agencies and community-based organizations provide a variety of services intended to meet many of the needs of high-risk families (CWIG, 2008). The benefits of these joint
efforts include increasing protective factors and resilience (DHHS, 2008); providing relief to children from harmful and ineffective caregiving practices (Dicker & Gordon, 2004); and reducing the risk of long-term physical, emotional, and mental health problems (Grogan-Kaylor, Ruffolo, Ortega, & Clarke, 2008).

While it is the overarching goal of CWS to protect children, removing children from their primary caregivers and placing them in out-of-home care is not without risk. Indeed, the common practice of removing children from at-risk homes and subsequent placement in foster care can erode already disrupted parent-child attachments (Dicker & Gordon, 2004; Dozier, et al., 2006). Likewise, repeatedly moving a child from one foster home to another, or back and forth from home to foster care, may potentially exacerbate attachment insecurities (Dicker & Gordon, 2004; Dozier, et al., 2006; Fonagy, 2003).

Earlier age at entry into the foster care system, increased length of time in out-of-home-placements, multiple moves, and failure of primary care providers to access available mental health services for foster youth have been implicated in long-term negative outcomes (Dicker & Gordon, 2004). Some negative outcomes identified with childhood CWS involvement consist of increased juvenile delinquency and adult criminal behaviors (Dicker & Gordon, 2004; Dozier, et al., 2006; Grogan-Kaylor, et al., 2008; Jonson-Reid, 2002), increased school drop-out rates, adolescent pregnancy, adolescent and adult homelessness (Dicker & Gordon, 2004), and early substance abuse (Dicker & Gordon, 2004; Dozier, et al., 2006).
Statement of the Problem

Of a certainty, these and many other outcomes related to child maltreatment and CWS involvement are serious points of consideration. Although Child Welfare often offers an assortment of services to at-risk caregivers, such as parent education and home visits, empirically, outcomes of these programs have had mixed results (Bilukha, et al., 2005; Casanueva, Martin, Runyan, Barth, & Bradley, 2008; Krysik, LeCroy, & Ashford, 2007; McElroy & Rodriguez, 2008; Olds, Sadler, & Kitzman, 2007; Weiss & Klein, 2006). Given the potential negative outcomes of child maltreatment and subsequent CWS involvement, it is important to develop effective interventions that prevent further harm to children by enhancing nurturing parenting practices, parent-child attachments, and resiliency.

Purpose of the Study

It is the premise of this project that one cannot give what s/he does not have. The Family Life Skills Home Visitation (FLS) program has been designed to improve positive parenting behaviors in at-risk families with open CWS cases. FLS uses an integrative approach including individualized parent education and instruction in floortime. The hope is that by improving parental knowledge and empathic awareness, parents will be sensitively responsive to the attachment needs of their children. Thus, the primary purpose of this project is to evaluate the Family Life Skills program and offer a qualitative analysis as to its effectiveness to improve parenting knowledge, attitudes, and behaviors among a sample of at-risk parents with open CWS cases. This information will be used to expand the knowledge of working with this at-risk population, as well as to
develop curriculum to be used in the Family Life Skills program specifically aimed at reducing the risk of recurring child maltreatment.

**Personal Interest in the Problem**

This topic came to the attention of the author while working with 1- to 5-year-old children in an emergency shelter. Children were usually placed in this shelter just after being removed from their homes by Child Welfare Services as investigations of child maltreatment allegations were begun. Children in this situation were naturally frightened. Regardless of the situations in which they lived on a day-to-day basis from birth, they wanted to go home. They wanted their parents but were instead left with rotating staff not always aware of their deepest needs for comfort, security, and attachment.

It was at this time that the author was completing an undergraduate degree in Child Development, and attachment theory became not just an intriguing conjecture but also a vital part of her work. After nightly visits between parents and children, it was this author’s job to comfort the children and try to help them know that their pain was understood and justified. While working to help children feel safe and secure in what, to them, was an unthinkable situation, questions started to stir. What about the pain of the parents? What happened to them? Does anyone hear their stories? Not to be derogatory, this author began to see parents accused of maltreating their children as larger versions of their children. Most parents, it can be assumed, do not bear children with the desire to do them harm. If their own attachment systems are impaired, how can parents do better? Is anyone addressing adult attachment issues with these heartsick parents?
The questions remained, and eventually this author had the opportunity to teach parenting classes to individuals with referrals from Child Welfare Services. Most of these parents have their children removed from their custody and placed in out-of-home settings. Previous questions began to be replaced by the awareness that, indeed, many parents who receive CWS services have themselves been victims of child maltreatment and/or otherwise find themselves in negative life circumstances that result in an inability to be fully present for their families. These are the same assumptions considered by the Family Life Skills program as reviewed here.

*Theoretical Frameworks*

*Attachment theory.* Attachment theory is the first and foremost theory used in this project. Ainsworth (1969) described attachment as a specific and discriminatory "affectional tie" that one person has toward another (p. 971). Bowlby (1982) elaborated in detail about the biological basis of human attachments and believed them to be ethological in nature. As Bowlby (1982) and Sroufe (2005) explain, attachment bonds are adaptive and necessary for the survival of the species, and are vitally important for development of the individual. As infants engage in attachment-seeking behaviors over time, they are met with reciprocal adult caretaking behaviors that ensure the caregiver's attention and proximity to the child. The child's attachment system is intended to ensure his/her protection from danger. Although the attachment system develops and is most actively seen during infancy and early childhood, one's attachment system is active throughout the lifespan and is most visible whenever an individual becomes distressed (Ainsworth, 1989; Bowlby, 1982).
Bioecological perspective. Although Bowlby (1982) considered attachment theory an ethological theory, it has elements of other theories such as psychodynamic, learning theory, cognitive theory, family systems, and information processing (Bretherton, 1992). Therefore, in addition to attachment theory, the author approaches the concepts presented in this project through the theoretical lens of the bioecological theory of human development as proposed by Bronfenbrenner (2005). Bioecological theory posits that we live in systems embedded in systems. The child comes into the world with a unique temperament and physiology that predisposes and drives the direction of developmental pathways in many respects. Yet, the child resides within a family system, located in a community, in a culture, and a society in an historical era. The systems and persons within the systems are reciprocally interrelated; thus, the child affects his/her environment and vice versa (Bronfenbrenner, 2005).

Keeping this perspective in mind, a shift can be made from studying the challenges associated with child maltreatment, insecure attachments, and intergenerational transmission of family dysfunction to offering hope for change and resilience. When CWS intervenes, few parents initially view the experience as an opportunity to change the course of history for themselves and their children. By using the bioecological perspective, linkages can be made from past, to present, to future. When the adult begins to change his/her lifestyle by entering into recovery (in whatever form that takes for that specific person) and not just passively accepting, but inviting the services offered by CWS, the chance for breaking the intergenerational systems of dysfunction and violence and enhancing parent-child attachments increases.
Research Question

This project is an evaluative study of the second phase of a two-part home visitation program for parents who have open cases with Child Welfare Services and are in the process of reunification. The original project from which the data for this project is derived used an individualized approach to parent education provided during home visits using the method of floortime. Therefore, the research question for the project presently reported is: Does using facilitator-guided floortime during home visits enhance positive parent-child interactions and increase individualized parental knowledge, attitudes, and behaviors?

Definition of Terms

At this juncture, a conceptualization of terms used in this project will be provided. First, the author recognizes the fact that not all children are raised by their biological parents, thus the terms parent and caregiver will be used interchangeably to refer to the child's primary care provider. For the purpose of this study, the term at-risk refers to primary caregivers or families who have one or more vulnerable life conditions that increase the potential for child maltreatment and CWS involvement. Examples of at-risk conditions are poverty (Egeland & Sroufe, 1981; Sroufe, 2005) and lack of parental educational attainment (Egeland & Sroufe, 1981; Rosenblum, McDonough, Sameroff, & Muzik, 2008). Rejecting or harsh parenting behaviors (Allen, Porter, McFarland, McElhaney, & Marsh, 2007), parental childhood maltreatment and attachment insecurities (Bifulco, et al., 2006; Cicchetti, Rogosch, & Toth, 2006; Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008), history of substance abuse (Polansky,
Lauterbach, Litzke, Coulter, & Sommers, 2006), family violence (Cloitre, et al., 2008), mental health issues (Bifulco, et al., 2006; O’Connell, 2008) and child disabilities (Dicker & Gordon, 2004) are other factors that put families at-risk. This list is not inclusive, nor is it implied that all families where these conditions exist are those where child maltreatment exists.

*Attachment* has been defined as a special affective connection between a child and her/his primary caregiver (Ainsworth, 1969). Likewise, an *attachment figure* is the person to whom the child is most intimately and emotionally connected. Attachment figures are very often parents, but for many, the attachment figure may be another relative or important person in the child’s life. *Secure attachments* are those where the child is able to feel secure and confident in the caregiver to meet her/his needs, while an *insecure attachment* leaves the child feeling confused, angry, withdrawn, and generally distrusting of others (Siegel, 1999). *Child maltreatment* refers to any form of abuse or neglect. *Abuse* can be physical, emotional, verbal, mental, or sexual, while *neglect* can include failure to protect, or not taking care of the physical, emotional, educational, or medical needs of the child.

Parenting attitudes and behaviors considered important for the development of secure attachments and reduction of possible child maltreatment include 1) having age-appropriate expectations of children, 2) empathic awareness of the child’s needs, 3) adhering to alternatives to physical punishment, 4) having appropriate ideas about parent-child roles, and 5) belief in empowering children (Palusci, Crum, Bliss, & Bavolek, 2008). Taken together these five constructs are measured in the *Adult-Adolescent*
Parenting Inventory (AAPI-2) and are considered nurturing parenting practices (Bavolek & Keene, 2001).

One term within these constructs requires additional explanation. Empathic awareness relates to having the knowledge and understanding that the child is a separate person with his/her own thoughts, feelings, emotions, motives, intentions, and needs. Oppenheim, Koren-Karie, and Sagi (2001) connect various terms that describe this phenomenon such as empathic awareness, parental mental representations, reflective functioning, and mind-mindedness. The construct under consideration in this thesis project will be described as empathy; however, whatever specific term is used, it is important to note that this construct is highly and significantly correlated with the development of secure attachments in children and reduced risk for child maltreatment (Laranjo, Bernier, & Meins, 2008; McElroy & Rodriguez, 2008; Oppenheim, et al., 2001; Perry, 2001).

Finally, many authors have speculated that parental sensitivity is the result of empathic understanding (Biringen, 2000; Lok & McMahon, 2006; Oppenheim, et al., 2001; Stayton & Ainsworth, 1973; Trapolini, Ungerer, & McMahon, 2008). Sensitive responsiveness involves the parent’s ability to accurately perceive and respond to the physical and emotional attachment signals of the child and has been shown to be the most accurate predictor of the development of secure attachments in children (Biringen, 2000; Nievar & Becker, 2007; Stayton & Ainsworth, 1973).

**Justification for the Research Project**

It is expected that this study will benefit the primary stakeholders, Yolo County CWS
and CommuniCare Health Centers (hereafter, the agency) and program being evaluated, as to the effectiveness of the Family Life Skills program. Further, the results of this project will guide future development and expansion of the policies and services to parents with open CWS cases for the improvement of parenting interventions for at-risk parents.

Limits of the Project

Considering this project is a program evaluation of a specific program in one agency, internal and external validity and reliability are expected to be poor. Furthermore, there are no participant-completed scales or program evaluation instruments. Therefore, conclusions will not be generalizable to any population outside the Family Life Skills Home Visitation Program. All information provided by CWS, FLS program facilitators, and participants is derived from case files that include referral forms, progress notes, and discharge summaries. Most of the information is derived from subjective and anecdotal staff notes in the files and, therefore, may provide an inaccurate analysis of constructs explored by this project.

Summary

Resilience as defined by Luthar, Cicchetti, and Becker (2000) is "a dynamic process encompassing positive adaptation within the context of significant adversity" (p. 543). Resilience may not always be a reality for individuals and families involved with Child Welfare Services, but the researcher proceeds under the philosophy that resilience is always a possibility. Research bears out that most persons who are abused, neglected, or otherwise reared in less than favorable circumstances do not go on to repeat cycles of
family dysfunction and/or violence or experience great difficulties later in life (Levinson, 2002; Sidebotham & Golding, 2001; Sroufe, 2005). Yet, of caregivers who abuse their children, there is a high likelihood that they were themselves abused as children (Levinson, 2002). In like manner, a similar pattern can be seen in the intergenerational transfer of attachment insecurities/securities.

When considering the vast numbers of families who become involved with CWS each year, the potential for recurrent reports of child maltreatment, and the potential negative effects of child maltreatment and CWS involvement, the topics discussed here hold a great deal of importance for the health and well-being of future generations. Indeed, there is hope for a better future for many. As Ainsworth (1969) noted many years ago, since parent-child attachment interactions are situational in nature, they may also be “strengthened’ situationally” (p. 1013). Providing early interventions to children and families in the prevention of initial or recurring child maltreatment increases the capacity for resilience and provides opportunity to abort intergenerational cycles of familial disadvantage and/or dysfunction (Cicchetti, et al., 2006; Siegel, 1999; Sroufe, 2005). These are the goals of the Family Life Skills Home Visitation Program. The author hypothesizes that by providing parent education and support through the model of floortime, the Family Life Skills program will have a positive influence on parental empathic awareness and nurturing parenting behaviors as evidenced by participants exhibiting more positive, appropriate parental responses over the course of the program.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

Formal home visitation programs have long been used to provide services to at-risk individuals and families with "friendly visitors" from the Charity Organization Society being the first home visitors recorded in the U.S. in the 1880s (Blau & Abramovitz, 2004). Indeed, outreach through home visitation has been a mainstay of social work, though at times waxing and waning, since the inception of the profession. It is estimated there are more than 4,000 children and families receiving home visits from a variety of professionals and paraprofessionals in the U.S. today (Weiss & Klein, 2006). Home visitation programs are typically aimed at improving pregnancy outcomes as well as child health and development, enhancing family functioning, promoting positive parenting, preventing child maltreatment, and maximizing children’s chances for success in school.

The Family Life Skills (FLS) program evaluated in this report utilizes the venue of the home to provide a unique blend of services to at-risk families intended to improve family functioning and enhance secure parent-child attachments. Services include individualized parent education, support, and instruction in the method of floortime. The intended purpose of FLS is to increase parental empathic awareness and sensitive responsiveness. The ultimate objective is to decrease risk of recurrent reports and occurrences of child maltreatment, while augmenting parent-child attachments and family resilience. In this chapter, each of these concepts will be investigated through a thorough discussion of the literature. First, an overview of attachment theory will be given. An
overview of home visitation programs and parenting programs will then be reviewed, followed by a more detailed analysis of attachment-based, nurturing parenting education programs. Finally, parent-child intervention utilizing the DIR®/Floortime™ model will be discussed.

Attachment Systems

Since the seminal works of John Bowlby and Mary Ainsworth in the 1950s and 1960s, an abundance of literature has emerged on the topic of childhood and adult attachment. Attachment, as used in this report, relates to the emotional connection that an infant develops with his/her primary caregiver/s (Ainsworth, 1969; Ainsworth, 1989; Bowlby, 1982; Sroufe, 2005). It is activated when the child has a need or is in distress and results in the child seeking protection and comfort from the caregiver. The foundation that is laid with attachment in childhood is one that has lifelong effects. Certainly, attachment securities can shift, but without intervention, the attachments that are developed in the first few years of life are often stable and enduring and tend to be transferred transgenerationally (Ainsworth, 1969; Bavolek, 2000; Bowlby, 1982; Perry, 2001; Siegel, 1999; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000).

For individuals who have grown up with parents with secure attachments, the outlook is good. Where familial difficulties abound, however, children are at-risk for developing insecure attachments and then perpetuating various cycles of dysfunction in the lives of their children. The variety of risk factors that result in families becoming involved with Child Welfare Services present some of the most insidious challenges many children
face, and, in many cases, family violence and neglect are closely connected to poorly
developed parent-child attachments.

The Development of Attachment

*Contingent parental responses.* Bowlby (1982) describes children as active
participants in the development of attachment but, naturally, much rests on the initiations
and responses of the child’s attachment figure. When the child’s attachment-seeking
behavior is activated, the caregiver’s response, for the most part, must be consistent,
appropriate, and warm or sensitive (Ainsworth, 1969; Bowlby, 1982; Stayton &
Ainsworth, 1973). Repeated many times a day, every day, the child learns to trust the
caregiver, and trust is the foundation of secure attachments (Figure 1).

![Figure 1. Development of secure attachment in childhood.](image)

However, simple parent-child interactions will not suffice. If the caregiver’s
responses are inconsistent, demeanor is angry, or handling is rough or intrusive, the child
will perceive mixed messages about whether s/he can trust the parent (Ainsworth, Blehar, Waters, & Wall, 1978; Brown & Whiteside, 2008; Siegel, 1999; Suchman, DeCoste, Castiglioni, Legow, & Mayes, 2008). Inconsistent, hostile, and/or intrusive parenting can result in disrupted attachments that are anxious/ambivalent, avoidant (Ainsworth, et al., 1978) or disorganized (Main & Solomon, as cited in Greenberg, Cicchetti, & Cummings, 1990).

*Neurobiological responses.* Detailing neurobiological processes, Siegel (1999) describes the development of attachment as an integrative process that involves “behavior, emotion, perceptions, sensations, and models of others (that become ingrained) by experiences that occur before children have autobiographical memory processes available to them” (p. 5). Siegel (1999) describes two types of memory that are involved in the development of attachments. One is explicit and the other is implicit memory. Explicit memories do not begin to develop until around two years of age, and they require conscious awareness, focused attention, reasoning ability, and encoding by the hippocampus. Explicit memories are those that one recalls as factual or autobiographical where one can place oneself in space or time in the memory. They are stored in the prefrontal cortex and are usually recalled as words or pictures. Certainly, memories that children have of their caregivers and environments are important to their development, but they do not begin to depict the whole picture.

In contrast to explicit memories, Siegel (1999) believes implicit memories begin at birth, possibly even when the child is still in the womb. Implicit memories are processed and stored in the more primitive parts of the brain. They do not require language, focused
attention, or higher cognitive processes. Implicit memories help children form
generalizations and mental models, or schemas, of how the world is for them in a more
perceptual, sensory mode. These earliest forms of memory are not recalled as facts or
events, and, thus, may be responsible for the phenomenon of infant amnesia. Yet, as
Siegel (1999) explains, implicit memory plays a large role in the development of
attachment.

Bioecological pathways. Greenspan and Wieder (2006) add to this discussion as they
link the two concepts previously discussed. It is their assumption there are two key
pathways that lead to the development of attachment systems. The first considers
environmental factors such as parental capacity to provide nurturing interactions
necessary for the development of relationship. Issues of family violence, stressful family
relationships, and abusive or neglectful behaviors are important to the development of
attachment systems. Other environmental factors are poverty, illness, and family
breakdowns. The second pathway considers the child’s unique physiological and
temperamental makeup and his/her ability to contribute to relationships. This concept is
akin to the bioecological stance of this study as elaborated by Bronfenbrenner (2005). It
makes sense, then that both parent and child contribute to the attachment system but the
burden rests with the adult to help the child develop optimally.

Links between Attachment and Child Maltreatment

Furthermore, Siegel (1999) explains that trauma experienced at any age has the
potential to cause the hippocampus to shut down resulting in dissociation and impaired
reasoning and social functioning. During traumatic experiences such as child
maltreatment and forced removal from the home, Siegel (1999) claims that perceptions bypass the conscious encoding functions of the hippocampus and are remembered indirectly, or as “gists.” These implicit memories can later be triggered when one is in a similar distressing situation. An example of this phenomenon is when a parent who was neglected and rejected by her primary caregiver, consistently misperceives her child’s attempts to become autonomous as rejection. It is not unusual for the parent who lacks insight into her own subjective experience to also lack empathic understanding of her child. In such a case, the caregiver may continue to respond in similar ways as when she initially experienced neglect and rejection as a child (Greenspan, 2007; Siegel, 1999).

**Intergenerational Transmission of Attachment Systems**

Given the long-lasting effects of attachment, many authors have clearly demonstrated the intergenerational nature of attachment systems (Bowlby, 1982; Bavolek, 2000; Cassidy & Shaver, 1999; Polansky, et al., 2006; Perry, 2001; Sroufe, 2005). There are strong correlations between parental attachments/behaviors and poor outcomes mediated by childhood maltreatment, including use of harsh and/or rejecting physical, emotional, or verbal punishment (Allen, et al., 2007; Bifulco, et al., 2006; Egeland & Sroufe, 1981; McElroy & Rodriguez, 2008; Perez & Fox, 2008). Some predictive factors of poor outcomes for children who have insecure attachments are history of family violence (Cloitre, et al., 2008) and parental experience of childhood maltreatment (Cloitre, et al., 2008; Egeland & Sroufe, 1981; Polansky, et al., 2006). Others include parental substance abuse (Egeland & Sroufe, 1981; Perry, 2001; Polansky, et al., 2006; Suchman, Mayes, Conti, Slade, & Rounsaville, 2004; Suchman, Pajulo, DeCoste, & Mayes, 2006), mental
health disorders (Cassidy & Shaver, 1999; Perez & Fox, 2008; Perry, 2001; Suchman et al., 2004; Vando, Rhule-Louie, McMahon, & Spieker, 2008; Waters, et al., 2000), and persistent poverty (Sroufe, 2005).

**Resilience and Attachment**

Albeit the list for potential negative outcomes for individuals with insecure attachment systems is quite long, as with maltreatment, most individuals who have insecure childhood attachments do not develop psychopathologies or experience difficulties later in life (Sroufe, 2005). Even though attachment systems are thought to last a lifetime, it is possible to shift attachment styles, depending upon changing life circumstances (Roisman, Padrón, Sroufe, Egeland, 2002; Sroufe, 2005). However, as would be expected, the longer an individual has been on a particular pathway, the more difficult it will be to change directions. Because of this, timely interventions are of particular importance when early experiences such as parental insecure attachments, mental health disorders, substance abuse, intimate partner violence, and/or child maltreatment have brought about participation with Child Welfare Services.

**Home Visitation Programs**

Recent studies have underscored the use of home-visitation programs as beneficial to reducing negative outcomes for children involved with CWS (Grogan-Kaylor, et al., 2008; Jonson-Reid, 2002). While in-home parenting support services show promise, the literature reveals varied results. For example, Bilukha, et al. (2005) conducted a meta-analysis of 21 longitudinal studies (with 26 intervention arms) of home visitations programs. In a systematic review, Bilukha, et al. (2005) evaluated the effectiveness of
home visitation services to reduce child maltreatment, as well as later violent adolescent and adult behaviors, excluding maltreatment. In 19 intervention arms, Bilukha, et al. (2005) report lower rates of child maltreatment among those receiving home visits. In the remaining seven intervention arms, however, child maltreatment had a higher incidence among those receiving interventions than those in control groups. Additionally, Bilukha, et al. (2005) found no difference between intervention and control groups in relation to other types of violent behaviors, including intimate partner violence.

Much literature on home visitation programs for at-risk families has been patterned after the Healthy Families America (HFA) program. HFA was initiated by the National Committee to Prevent Child Abuse (now Prevent Child Abuse America) in conjunction with the Ronald McDonald House Charities in 1992 (Prevent Child Abuse America [PCAA], n.d.). HFAs are typically long-term (up to five years) voluntary programs that take an ecological perspective. They generally commence during pregnancy or shortly after the birth of a child in an at-risk family. The primary purpose of HFAs is to promote positive parenting, prevent child maltreatment, and increase child and family health and well-being (PCAA, n.d.).

An analysis of four statewide child abuse prevention programs patterned after HFA reveals limited effectiveness in preventing child maltreatment. Program recruiters typically screen for maltreatment risk during pregnancy or shortly after birth. Random assignment to a control group or an intervention group is then made (Duggan, et al., 2004; Duggan, et al., 2007; DuMont, et al., 2008; Gessner, 2008). Attenuated services, beginning with weekly home visits, are geared toward offering parent education and skill
development. Home visitors work to establish a trusting relationship with program participants and then model positive parenting skills, communication, problem solving and stress-reduction techniques, and alternatives to corporal punishment. Home visitors are often expected to help families resolve crises and address issues such as parental substance abuse, mental health problems, and intimate partner violence by assisting parents in accessing outside resources.

Of the HFA studies reviewed, only small, statistically non-significant correlations were found between program participation and reductions in minor verbal aggression, minor physical punishment, and child neglect (Duggan, et al., 2004; Duggan, et al., 2007; Gessner, 2008). Of the programs reviewed, one common theme emerged; HFA-based programs were reported less effective among those whose risks for child maltreatment were deemed the highest. For example, in a study of an HFA conducted in a rural area, Whipple and Nathans (2005) found less effectiveness among young mothers who were less educated, had scant employment histories, more children, and less paternal involvement. For these women, Whipple and Nathans (2005) found, shorter, more concrete programs that included case management to address the basic needs of the participants worked better than parenting education provided through home visitation programs.

DuMont, et al. (2008) report that outcomes can be improved by making HFA services available to first-time mothers at 30 weeks gestation. In comparison to control subjects, program participants were less inclined to use minor physical punishment in the previous year and less harsh punishment in the previous week. Participants in Healthy Families
New York committed one-fourth as many acts of serious abuse as individuals in the control group up to two years post-intervention. Even among those identified as "psychologically vulnerable," there were one-fourth as many reports of serious abuse and neglect as parents in the control group (DuMont, et al., 2008).

One surprising finding noted by Duggan, et al. (2004) and Duggan, et al. (2007) was that, although home visitors seemed to receive adequate training in recognizing high-risk parenting practices, recorded risk factors were abysmally absent in progress notes even among those displaying the highest levels of abusive parenting attitudes and behaviors. Although all records were available to researchers and detailed notes of home visits recorded and signed off by supervisors, home visitors rarely indicated concerns about potential abuse. Duggan, et al. (2004) conjecture that implementation changes in program procedures may be responsible for this finding. In the mid-1990s, they report there was a philosophical shift from identifying child maltreatment risks to a strengths-based perspective that allowed participants to identify their own concerns and goals. Fine tuning of home visitor and supervisor training to focus more on identifying and targeting maltreatment risk factors and providing better community linkages for those with a multitude of risk factors (e.g., mental health disorders, substance abuse, intimate partner violence, and poverty) are expected to improve HFA programs (Duggan, et al., 2004).

**Parenting Education**

*Mandated parenting courses.* Typically, when a family becomes involved in CWS, there are a series of steps set before the parent. The specific steps are usually based on the individual needs of the parent/s and family. A common requirement is that parents enroll
in parenting courses, whether in a group-based setting, individualized home visitation programs, or both. A plethora of parent education programs have emerged and been evaluated in the recent past with many showing promise in not only improving parenting skills and techniques, but also in improving parent-child attachments. Yet, results of these programs have also been unclear with respect to the prevention of child maltreatment.

**Behavior management.** Debates have also been waged with regard to approaches that focus primarily on behavior management as opposed to attachment-based approaches. In a meta-analysis of longitudinal studies examining the effectiveness of various parenting education courses, Suchman, et al. (2006) report virtually no long-term differences between participants receiving behavioral-based parenting interventions and those in control groups. This is not an unusual finding, and several researchers have speculated about the reasons why parent education courses based on behavior management skills fail to elicit long-term changes among at-risk parents. The primary hypothesis seems to be that simply attempting to improve parenting techniques without appealing to the emotional attachment needs of parents does little to change the way parents think about their children (Sroufe, 2005; Suchman, et al., 2006).

To take the discussion a step further, Sroufe (2005) speculates that behavioral-based approaches highlight such concepts as consistency. While consistency is vital, at-risk caregivers often have difficulty in that area. In fact, it is speculated that inconsistency, in part, contributes to the development of insecure attachments to begin with. Suchman, et al. (2006) point out, when parents experience lack of emotional regulation, as is common for many who encounter Child Welfare Services, ability to respond to children in
nurturing, empathic ways is limited. This, in turn, limits the child’s capacity for emotion regulation and the development of feelings of inner security.

**Attachment-based programs.** Conversely, attachment-based programs have been shown to have more success with at-risk families to reduce internalizing and externalizing behaviors, as well as to shift attachments securities in young children (Hoffman, Marvin, Cooper, & Powell, 2006; Moore & Finkelstein, 2001; Polansky, et al., 2006; Suchman, et al., 2006). While a variety of methods and constructs have been examined in attachment-based parenting programs, the goal of many programs is similar: to improve parental capacity to correctly perceive, interpret, and respond sensitively to the child’s attachment behaviors. This approach is in step with recommendations provided by Ainsworth, et al. (1978) who observed that one commonality among the three anxious-insecure attachment types was caregiver misreading attachment signals.

The conclusion reached by several researchers is that best practice for parenting education courses for at-risk caregivers would be a multi-faceted approach incorporating cognitive, social/relational, and affective components (Bavolek, 2000; Greenspan, 2002; Suchman, et al., 2004; Siegel, 1999). Such an approach would provide an opportunity to improve parental knowledge and empathic understanding critical to enhancing attachment (Perry, 2001) and reducing risks related to child maltreatment (Suchman, et al., 2004).

**Nurturing Parenting Programs**

*The Bavolek model.* One such integrative approach to parent training is the Nurturing Parenting programs developed by Bavolek (2000). According to Bavolek (2000),
parenting interventions aimed at improving parent-child attachments in at-risk families must first consider the family system that encompasses the personal and family history of the parent/s, in addition to past and current parent-child interactions. Bavolek (2000) explains that nurturing parenting practices are closely linked to the development of a positive self-image that consists of thoughts (self-concept) and feelings (self-esteem) about oneself as a valuable human being. This, in turn, can affect the way the caregiver parents the child.

The premise of the Nurturing Parenting programs is that by increasing parental insightfulness, empathic understanding, and knowledge of child development and appropriate parent-child roles and interactions, the quality of parent-child attachments will improve and the potential for child maltreatment will decrease. Other primary assumptions of the Nurturing Parenting programs are that the family is a system and, as such, when caregivers are able to more appropriately meet their own nurturing needs, they are more capable of meeting the nurturing needs of their children. Another philosophical underpinning of Nurturing Parenting is that parenting exists on a continuum. Since there is no “right” way to parent children, individuality and respect for cultural diversity are key components of the programs¹ (Bavolek, 2000).

¹ There are currently 17 different Nurturing Parenting programs for parents of children of every age and includes culturally focused programs for Christian, African American, Spanish-speaking, and Hmong parents.
Components of Nurturing Parenting

Developmentally appropriate expectations. Parents who have inappropriate developmental expectations are those whose expectations of their children exceed their physiological or emotional developmental capacity (Bavolek, 2000; Bavolek & Greene, 2005; Palusci, et al., 2008). These caregivers lack age-appropriate developmental knowledge and tend to be more demanding and controlling of their children. McElroy and Rodriguez (2008) add that caregivers who have inappropriate expectations of their children are more likely to perceive “misbehaviors” as purposive, which increases risk for child maltreatment (McElroy & Rodriguez, 2008). Increasing parental knowledge of developmental stages, therefore, can decrease maltreatment risk (Bavolek, 2000; Bavolek & Greene, 2005; Cicchetti, et al., 2006; Moore & Finkelstein, 2001; Palusci, et al., 2008; Thomas & Looney, 2004).

Parental empathy. Empathy is foundational in the Nurturing Parenting programs. As Bavolek (2000) states, empathy is the “single most desirable quality in nurturing parenting,” (p. 5). Gordon (2003) elaborates that lack of empathy is the one common factor found among aggressive, maltreating caregivers. Moreover, Oppenheim, et al. (2001) describe parental empathy as the “mental correlate of sensitive caregiving behaviors” (p. 17). Indeed, being able to respond sensitively to the child’s needs helps the child build a sense of trust and security in his/her caregiver and the world at large. Parental empathy helps the child regulate his/her emotions, use more socially acceptable skills in getting his/her personal needs met, and, ultimately, to develop more prosocial,
intimate, and empathic relationships (Brazelton & Greenspan, 2006; Thompson & Gullone, 2008).

**Alternatives to corporal punishment.** Biringen (2000), among others, describes parental nonhostility as the caregiver’s ability to respond to the child in a calm, patient manner. When frustrated or angry, Biringen explains, a nonhostile parent is one who is able to explain his/her thoughts and feelings in an assertive and controlled manner. As Lok and McMahon (2006) report, there are strong correlations between parental sensitivity and nonhostility, and nonhostility and mind-mindedness (having empathic understanding for another). Alternatively, it has been speculated that when caregivers lack appropriate developmental knowledge and the ability to take the child’s perspective, decreased capacity to tolerate the normal frustrations of childrearing may lead to maladaptive and harsh parenting behaviors (Cicchetti, et al., 2006; McElroy & Rodriguez, 2008).

**Appropriate parent-child roles.** Parentification is a common problem seen in many children who become involved in the Child Welfare system (Perry, 2001). Parentification occurs when children must care for themselves, their younger siblings, and/or their parents (Ainsworth, 1989; Perry, 2001). Appropriate family roles require that the parent meet the child’s needs for comfort, assurance, and love, not the other way around (Bavolek, 2000; Bavolek & Greene, 2005). When children are used to meet their parents’ needs, they become objects of gratification and often become privy to inappropriate parental knowledge and information. The result of reversed family roles may be poor self-awareness, low self-esteem, and social incompetence (Palusci, et al., 2008), as well
as social isolation and depression (O'Connell, 2008). Ultimately, the parentified child may parent her/his own children in the same rejecting and neglectful manner as s/he was parented (Perry, 2001).

Child autonomy and empowerment. According to Bavolek and Greene (2005), maltreating caregivers tend to restrict their children’s power and independence. They are inclined to take a stricter, authoritarian approach to parenting and expect unquestioning obedience to all adult demands. Independent thinking may be perceived as disrespectful, and family problem solving is devoid of compromise or negotiation (Bavolek & Greene, 2005). On the other hand, Stayton and Ainsworth (1973) identified a strong correlation between the concepts of child empowerment (described as parental cooperation or nonintrusiveness)\(^2\) and secure attachment.

Nonintrusiveness allows for a convergence of the various constructs found in nurturing parenting practices. As defined by Stayton and Ainsworth (1973), parental cooperation perceives the child as a separate person rather than an extension of the adult. Biringen (2000) elaborates; nonintrusiveness allows the parent to be emotionally available to the child without taking charge, being too controlling, or overpowering. The nonintrusive caregiver tends to use indirect, diversionary techniques to teach child compliance. S/he is apt to listen empathically, allows the child to develop autonomy through giving age-appropriate choices, and is more likely to allow the child to discover

\(^2\) Stayton and Ainsworth described their constructs on continua; thus, the concept referred to here on Stayton and Ainsworth’s measures is “Cooperation-Interference.” On Biringen’s (2000) Emotional Availability Scale, the same concept is operationalized simply as parental nonintrusiveness.
his/her own solutions in challenging circumstances (Biringen, 2000). The goal of this construct is respect and empathic acceptance of the child.

*Application of Nurturing Parenting Programs*

*NIMH study.* The original Nurturing Program by Bavolek (2000) was the product of a two-year study begun in 1979, funded by the National Institutes of Mental Health (NIMH). The purpose of the program has been the same since its inception – to end the cycle of family violence. Results of the 1979 study showed reduction of 42 percent at one-year post intervention in involvement with CWS, from 58 percent to 16. In addition, only seven caregivers had repeat maltreatment allegations. Overall, scores on the AAPI (the original version) showed significant increases in the constructs of age-appropriate expectations and empathy, beliefs in alternative to corporal punishment, and appropriate parent-child roles (Bavolek, 2000).

*Incarcerated and other at-risk parents.* Since those early days, research on the effectiveness of Nurturing Parenting programs has been conducted in many differing contexts. For example, in their large multi-site study, Palusci, et al. (2008) used modified versions of Nurturing Parenting programs to provide parenting education to at-risk parents who were incarcerated and participating in substance abuse treatment or batterers programs, enrolled in residential substance abuse treatment, or were participants in community-based programs, including a week-long family camp. Overall, significant gains were exhibited in this large sample of high-risk caregivers, as scores on the AAPI-2 significantly increased from pre-test to post-test in all the domains with the exception of child empowerment and autonomy. One surprising finding in Palusci, et al. (2008) is that
males scored lower than females on both pre- and post-tests, but they had greater gains in
their scores overall.

Adolescent parents. Lastly, Thomas and Looney (2004) conducted a small study in
two locations – a rural alternative school and a residential treatment facility – with
adolescent parents, many of whom were depressed. Although Thomas and Looney did
not use Nurturing Parenting curriculum, they based their study on nurturing parenting
principles and used the AAPI-2 (Bavolek & Keene, 2001) to evaluate their program.
Parenting sessions lasted 12 weeks and, like Family Life Skills, there was a second phase
grounded toward health promotion.

Despite the fact that there were significant, average increases on the AAPI-2 from
pre- to post-test, changes did not reach statistical significance. When Thomas and Looney
(2004) evaluated the constructs of the AAPI-2 individually and compared scores by
program site, they report increases in appropriate expectations, beliefs in alternatives to
corporal punishment, and appropriate parent-child roles. There were no significant
changes in the constructs of empathy and child empowerment, nor were there differences
according to program location or any improvements noted in the levels of depression or
self-esteem of the adolescent mothers.

Even though they expected to see an increase in positive self-esteem, Thomas and
Looney (2004) state that the lack of change in depression is not surprising since the
parenting program targeted parenting practices, not alleviating depression. Thomas and
Looney (2004) also report a very high attrition rate (54 percent). Given the situations in
which the programs were offered this is also not surprising. Findings in this study
correspond with other studies that report younger age, coupled with other factors (e.g.,
single parenting, lower educational levels, problematic circumstances, mental health
problems) increase risks overall for abusive parenting practices (DuMont, et al., 2008;
Jacinthe, Daniel, & Marc, 2008; Kettinger, Nair, & Schuler, 2000).

**DIR®/Floortime™ Model**

*Principles of floortime.* Another program showing positive results in improving
parent-child interactions is the DIR®/Floortime™ (Developmental, Individual-
Difference, Relationship-Based) model. Floortime is only one component within the
DIR® model developed by Drs. Greenspan and Wieder. DIR®/Floortime™ has been
successful in interventions with children with a wide range of developmental difficulties
and challenges including those with autistic spectrum disorders (Greenspan & Wieder,
2006). Other groups of children who have benefited from the DIR® model are those who
have sensory processing and integration challenges, attentional problems, or who are very
self-absorbed or, on the other end of the spectrum, very active and aggressive (Greenspan
& Wieder, 2006). However, as Greenspan (2002) discusses, even though the
DIR®/Floortime™ has been more widely used with children who have
neurodevelopmental disorders, it originated as a model of child development for the
typically developing child.

Floortime is a form of parent-child interaction used to increase the emotional
connection between the child and his/her caregiver. Engaging in floortime simply

---

3 The DIR®/Floortime™ is a complex child development model of which only the floortime component is
used in the Family Life Skills program with at-risk families.
requires that the adult get on the child’s level and let the child lead the activities. During infancy and early childhood, parents are encouraged to get on the floor with the child, but floortime can be done in any location and with a youngster of any age. With adolescents, for example, the principles of floortime might be incorporated during “hang-out time” (Greenspan, 2002, p. 144). The job of the caregiver in floortime is to expand on the child’s play to help the child reach his/her maximal emotional developmental milestones. The only “rules” are that the child is not allowed to hurt people or destroy property, and as Greenspan (2002) explains, floortime is not a time to teach, be controlling, or intrusive.

**Benefits of floortime.** Greenspan (2002) and Greenspan and Wieder (2006) contend there are a wide range of benefits from floortime for the parent-child relationship, and, more specifically, for the developing young person. In following the child’s lead during floortime, the caregiver tunes into the child’s temperamental and developmental levels. This, in turn, improves the caregiver’s capacity to be more empathic, enhances parental sensitive responsiveness, and has the potential to boost secure attachments. Engaging the child in floortime encourages the child to develop a strong sense of autonomy, communication skills, initiation, assertiveness, reasoning, problem-solving skills, personal morals and values, and social competence.

**Floortime for children with autism.** Literature on the effectiveness of floortime is sparse, and the few studies that exist focus on using floortime as a form of treatment for children with autistic spectrum disorders. One study examined the effectiveness of the PLAY Project Home Consultation program (Solomon, Necheles, Ferch, & Bruckman,
After receiving intensive one-day training in the DIR®/Floortime™ methods, parents were encouraged to engage their children in floortime for at least 15 hours per week. Parents could choose to set aside time for daily structured floortime with their children or apply the floortime principles to time naturally spent together such as during meals, children's baths, or bedtime.

Trained PLAY Project home consultants visited participating families for three to four hours one day per month for up to one year. Parent-child interactions during floortime were observed and video-recorded during home visits. Home visitors then coded and evaluated the videos and used them to give positive feedback to parents. Program facilitators also presented parents with individualized written objectives using baseline data from the Pre-School Autism Rating Scale (PARS) that parents could use to guide floortime practice between monthly home visits.

Solomon, et al. (2007) measured the effectiveness of the PLAY Project in several ways. First, the PARS provided baseline functioning levels of the children. Secondly, the researchers used the Functional Emotional Assessment Scale (FEAS) to code video recordings at baseline and at the end of the intervention to measure changes in parenting behaviors and progress in the six infant/child functional emotional levels identified by Greenspan and Wieder (2006). The six developmental domains measured by the FEAS are: 1) self-regulation and interest in the world; 2) forming relationships, attachment, and engagement; 3) two-way, purposeful communication; 4) behavioral organization, problem-solving, and internalization; 5) representational capacity and elaboration of
symbolic thinking; and 6) emotional thinking or development and expression of thematic play (Greenspan, DeGangi, & Wieder, 2003, p. 169).

From pre- to post-intervention, child subscale scores increased significantly on the FEAS \( p \leq 0.0001 \) showing that 45.5 percent of the children made good to very good progress in functional developmental areas. Home consultants rated the children’s progress even higher, with 66 percent of the children making very good progress. There were no changes in pre- and post-intervention scores on the parent subscales of the FEAS; however, as Solomon, et al. (2007) comment, 85 percent of the parents were appropriately interactive at baseline. Since the DIR®/Floortime™ model accounts for individual physiological, psychological, emotional, and relational differences, it appears a good model to use with families involved with Child Welfare Services who have histories of child maltreatment and possibly attachment dysfunctions.

**Conclusion**

In conclusion, the Family Life Skills Home Visitation Program is a unique and innovative approach to address the many varied and complex issues facing individuals who have open cases with Child Welfare Services. Although literature reveals mixed findings in the evaluations of many parenting education and home visitation programs to, researchers are reporting promising results from programs based on the Nurturing Parenting programs and the DIR®/Floortime™ model to improve parental knowledge, empathic attunement, and nurturing parenting practices.
Chapter 3

METHODS

Program Overview

The Family Life Skills Partnership Plan is a collaborative effort of county Child Welfare Services and two community-based organizations to provide services to at-risk individuals and families in a small, rural county in California. Family Life Skills (FLS) is the second phase in the two-phase Family Life Skills Partnership Plan. In the first phase, CWS workers refer parents to the 12-week Daily Living Skills (DLS) course offered by the first agency. After participants complete DLS, they receive referrals to Family Life Skills as offered by the agency connected with this project. CWS typically authorizes parents to have up to 12 sessions of FLS in-home parenting services. Home visitors (HVs) are professionals in the field of child development who have many years of training and experience working with children and families. During the period of this evaluation, there were four home visitors. Typically, one home visitor worked with a family throughout the term of the family’s involvement; however, at times, two visitors attended home visits. There were also shifts in home visitors when one HV was hired then later resigned, and during the term of an MSW intern’s field placement.

FLS outreach services usually start when families begin the process of reunification. For some parents, home visits will begin when they start getting unsupervised visits with their children. For others, services commence after children have already returned home. During the first visit, the HV conducts a brief intake assessment, where she reviews the parent’s completed Home Visitation Partnership Plan, obtains signed consent and
authorization to release information forms, and assists the parent in developing individualized goals for home visitation sessions. The HV then observes the parent/s and child/ren as they play together. The HV records areas of strengths and challenges as she looks for parental knowledge of basic child development and empathic perspective taking.

During subsequent sessions, the home visitor instructs the caregiver in taking the child’s lead during floortime, provides feedback regarding parent and child strengths, and models appropriate limit setting. Home visitors also deliver educational information related to such topics as child development and nurturing child-rearing practices as indicated by the level of interactions observed. Successful completion of the program occurs when caregivers have reached the authorized number of visits and the home visitor has documented sufficient progress. Terminations may also occur when parents experience substance abuse relapse, additional allegations of child maltreatment are filed, or the participant fails to keep home visitation appointments or otherwise indicates a desire to terminate services.

Purpose of the Study

This project attempts to address the question: Does providing in-home parent education and support, using facilitator-guided floortime, enhance positive parent-child interactions and increase individualized parental knowledge and attitudes? The purpose of this project is to evaluate the Family Life Skills Home Visitation program and provide empirical evidence as to its effectiveness in improving parental knowledge and attitudes and child-rearing practices among a sample of at-risk parents through use of facilitator-
guided floor-time. Findings from this evaluative project will expand the body of knowledge as it relates to the effectiveness of services provided to FLS participants with open Child Welfare cases. In addition, results will be used to develop and enhance the policies and services provided by the stakeholders (Yolo County CWS and CommuniCare Health Centers) to improve current parenting intervention services, enhance parent-child attachments, and decrease maltreatment recidivism rates.

**Project Design**

This project is a non-experimental program evaluation, using a qualitative approach and content analysis to evaluate the effectiveness of the FLS program. The author has chosen a qualitative approach for this project due to the distinctive capacity of qualitative research to gather “rich information about social processes in specific settings” (Kreuger & Neuman, 2006, p. 136).

Content analysis of program forms and notes found in FLS case files has been used to openly code and categorize themes related to nurturing parenting beliefs and behaviors as enumerated in the AAPI-2. Although the AAPI-2 was not directly used in the Family Life Skills program, the constructs are in keeping with the stated goals of the FLS program supervisor – to provide individualized, “hands on,” parent education to improve parental knowledge of child development and ability to focus more empathically on the child (S. Lomax, personal communication, November 21, 2008). Constructs of the AAPI-2 include 1) appropriate expectations of the child, 2) empathic awareness, 3) beliefs about corporal punishment, 4) appropriate parent-child roles, and 5) beliefs about child empowerment and autonomy.
Similar to the coding procedure recorded by Bavolek (2000) for the observational portion of the original 1979 NIMH study, as each theme has emerged from the content analysis, the author has subcategorized caregiving behaviors and attitudes as either appropriate or inappropriate. For example, if progress notes indicate that the parent gave a 5-year-old child a timeout after repeatedly asking the child to stop throwing a ball in the house, the author would consider this an appropriate use of discipline, as well as appropriate expectations of the child. If, however, the caregiver requires an 18-month-old to stand in a corner for a five-minute timeout for the same behavior, the researcher would consider this inappropriate expectations and an inappropriate use of discipline since children under two-and-a-half lack the reasoning ability of older children (Nelson, Erwin, & Duffy, 1998). Therefore, for each interaction recorded, there may be multiple categorizations.

Sample

No participants were directly involved in this project. The director of the agency administering FLS granted permission to the author to analyze and evaluate archived data from the Family Life Skills Home Visitation Program (Agency Authorization to Release Information on file with the researcher and available upon request). Data consists of a non-probability, convenience sample of caregivers referred by county Child Welfare Services to the Family Life Skills Home Visitation Program. The researcher obtained 30 case files of families who participated in FLS for any length of time between July 1, 2007 and June 30, 2008. Recorded data found in FLS case files includes CWS referrals, demographic data, participant plans and goals, evaluation forms, progress notes, and
discharge summaries (related paperwork on file with the researcher and available upon request). Criteria for inclusion in this project required that participant records contained all of the foregoing. Data from participants who did not meet all the criteria for inclusion were excluded. The researcher offered no incentives to obtain the information related to this project, as she was requested to participate in data coding, analyzation, and evaluation for the FLS program as a primary benefit to the agency.

Protection of Human Subjects

Since no human subjects directly participated in this project and only archival data used to evaluate the effectiveness of the FLS program, there is no harm or injury expected. It was the responsibility of the agency to collect and store signed, written consent forms from program participants; therefore, the researcher obtained no Informed Consent forms for this project. To protect confidentiality and anonymity of original participants, program records obtained by the author from the agency revealed no identifying information of caregivers or children. Additionally, all information reported in this project appears in aggregate and anecdotal form only. Finally, according to the policies and procedures of California State University, Sacramento, a Request for Review by the Committee for the Protection of Human Subjects was submitted and approved prior to release of documents to the author. This project was classified by the Human Subjects Committee as “exempt” due to the lack of human subjects and the exclusive use of archival data in the evaluation of the Family Life Skills Home Visitation Program.
Validity and Reliability

Considering this is a qualitative program evaluation of a specific program in one agency, internal and external validity and reliability are expected to be poor. Conclusions will not be generalizable to any other populations. Information recorded in participant case files by CWS, FLS Outreach Specialists, and participants is of a self-report nature, and is, therefore, subjective. For this reason, information released for this study may provide an inaccurate analysis of the constructs measured. Furthermore, there are no participant-completed scales or program evaluations that can be evaluated quantitatively. That said, the researcher is a Master’s of Social Work candidate who has had extensive training in research practices. To maintain the highest integrity, every attempt has been made to provide accurate and authentic accounts and interpretations of the material presented.
Chapter 4

FINDINGS

Introduction

This chapter provides an overview of the results obtained from the evaluation of the Family Life Skills (FLS) program. First, the researcher discusses the Family Life Skills contract requirements, compliance issues and their relation to data collection and analyzation. Description of demographic information follows and then a presentation of risk factors found among adult participants in the FLS program. Concerns and goals of Child Welfare workers, as well as of participants, are then noted. Next, a review of the themes that emerged in the evaluation of the FLS program is pursued. Specifically, themes chosen for evaluation and reported herein are appropriate caregiver expectations, empathy, discipline practices, parent-child roles, and beliefs about child empowerment and independence. Finally, the researcher considers program completion issues and expounds upon differences found among families who successfully completed FLS, those who completed but continued to experience various challenges, and families that had reversals of middle-phase progress.

Review of the FLS Contract and Data Collection Issues

A review of the Agreement between the county and the agency reveals that key objectives of the program are to assess for risk and reduce the incidence of child abuse and neglect. Using content analysis, the researcher qualitatively analyzed archived data in the form of case files. Thirty case files were released to the researcher. Of those, 22 fell within the period chosen for inclusion (July 1, 2007 to June 30, 2008) and 14 included all
the forms and records selected for analysis. Among excluded case files, the most often missing piece was the Closing Summary. Since the Closing Summary often offers a fuller depiction of progress made during participation, confirms dates of participation, and contains an overview by the home visitor, the researcher decided to include only case files where this form was present. Although this is a qualitative study and the number of files available for review was few, the researcher has provided numerical and nominal data expressed as number ($N; n$), percent (%) and, in the case of ages of participants, as means ($M$).

**Assessment Measures**

Assessment tools enumerated in the Family Life Skills contract include the Adult-Adolescent Parenting Inventory (AAPI-2), Maternal Social Support Inventory (MSSI), Drug Abuse Screening Test (DAST-10), Alcohol Use Disorders Identification Test (AUDIT), the Conflicts Tactics Scale (CTS), Center of Epidemiological Studies - Depression Scale (CES-D), and the Denver II Developmental Screening Test. The first six measures assess parenting attitudes and beliefs, level of social support, history of drug and alcohol use, level of family violence, and maternal depression. The Denver II assesses children's social skills, gross and fine motor development, and language skills. The Denver II can be used to increase parental awareness of children's developmental needs.

Upon examination of program materials and participant case files, with the exception of the Denver II, the researcher found no evidence that FLS home visitors used any of the scales denoted in the contract. However, the constructs of the AAPI-2, specifically, and
of the other measures, in general, are important to this study. Thus, lacking the specified scales, the researcher obtained demographic information from the Partnership Plan and the Family Information Form. History of substance abuse, mental health, family violence, legal problems, and level of social support were obtained from the referral form. Progress notes and closing summaries were used to code for caregiver attitudes and beliefs as they correlated to the AAPI-2. CWS workers indicated areas of concern and challenge for caregivers and children on referral forms. Parents self-identified levels of knowledge in various areas on the Intent to Participate and goals on the Participation Plan. When information was not found on the specific forms as described, the researcher attempted to locate information through other forms or progress notes found within the case files.

It is important to state that in only five of the nine dual-parent families was any information about adult males provided by CWS. In instances where there was a separate referral form for the father, only two contain most of the information. Thus, there is much missing data on fathers. In two instances, the researcher eliminated data on fathers due to lack of information and because the father either did not participate at all or only minimally. Additionally, where ages are noted, calculations do not include responses indicated as "unsure" or are otherwise unknown (e.g., missing data), unless specifically noted.

Demographics

Gender and ages of caregivers. The case files of 14 families were included in the program evaluation. There were 21 adults: 13 females ($n = 13; 61.90\%$) and 8 males ($n = 8; 38.10\%$). All of the females were reported to be the children's biological mothers.
Adult males were variously described as fathers, stepfathers, or both. In eight of the families, both mothers and fathers participated in FLS; however, due to lack of information on and minimal participation by one stepfather, demographic data on him is not included. In five families, only mothers participated, and in one family only father participated. Mothers ranged in age from 18 to 36 years ($n = 13; M = 26.77$) and fathers, from 24 to 47 years ($n = 8; M = 31.38$).

Adult racial/ethnic identity. Three parents ($n = 3; 14.29\%$) self-identified as Hispanic or Latino/a, one as Pacific Islander ($n = 1; 4.76\%$), and one as Native American ($n = 1; 4.76\%$). Thirteen caregivers were described as Caucasian ($n = 13; 61.90\%$), one as two or more races ($n = 1; 4.76\%$), and the race/ethnicity of two fathers ($n = 2; 9.52\%$) was not reported.

Marital status. In six families, parents reported they were married ($n = 6; 42.86\%$). One family was headed by unmarried partners ($n = 1; 7.14\%$), and three stated they were never married ($n = 3; 21.43\%$). One individual identified himself as divorced ($n = 1; 7.14\%$); two did not identify their marital status ($n = 2; 14.29\%$); and in one family ($n = 1; 7.14\%$), one mother reported she was single and the father as separated.

Educational attainment. Eight adult participants had less than a high school education ($n = 8; 38.10\%$); five had a high school diploma or GED ($n = 5; 23.81\%$). One person reported having an Associate’s degree or completing technical or trade school ($n = 1; 4.76\%$), seven had attended some college classes but had no college degree ($n = 7; 33.33\%$), and no participants completed bachelor’s degrees or higher.
Employment status. Eleven adults were in the labor force during their participation in FLS \((n = 11; 52.38\%)\), seven were not in the labor force \((n = 7; 33.33\%)\), one reported being disabled \((n = 1; 4.76\%)\), while employment status was not reported for two adults \((n = 2; 9.52\%)\).

Gender and ages of children. Although families often reported they had other children, the researcher includes only data for children who participated in Family Life Skills with their parents. In some cases, parental rights of nonparticipating children had been terminated, and, in other cases, nonparticipating children lived with another parent or family member who had guardianship. Thirty-three children \((N = 33)\) participated in FLS with their caregivers. At the outset of their participation, there were 13 males \((n = 13; 39.39\%)\) whose ages ranged from 2 months to 4 years \((M = 1.62)\), and 19 females \((n = 19; 57.58\%)\) with an age range of 4 months to 11 years \((M = 4.16)\). One infant \((n = 1; 3.03\%)\), whose gender was not recorded, was born during the family’s participation in FLS.

Race/ethnicity of children. Three children were reported as being African American \((n = 3; 9.09\%)\) and three as Hispanic/Latino/a \((n = 3; 9.09\%)\). Fourteen of the children were Caucasian \((n = 14; 42.42\%)\). Two were identified as Native American \((n = 2; 6.06\%)\), seven as two or more races/ethnicities \((n = 7; 21.21\%)\), one as some other race or ethnicity \((n = 1; 3.03\%)\). The racial/ethnic identity of three children was not reported \((n = 3; 9.09\%)\).
Child Maltreatment Allegations

A review of Family Life Skills case files reveals that the majority of the cases involved neglect as the alleged form of maltreatment ($n = 9; 64.29\%$). Other maltreatment types included physical abuse ($n = 1; 7.14\%$), sexual abuse ($n = 1; 7.14\%$), and emotional abuse ($n = 1; 7.14\%$). In three cases, maltreatment type was not indicated ($n = 3; 21.43\%$).

Risk Factors

Substance abuse (Figure 2). In this study, 15 caregivers were reported to have substance abuse issues ($n = 15; 78.95\%$). Only four individuals were reported as having no history of substance abuse ($n = 4; 21.05\%$), and data was not available for two adult participants. Of those reporting history of substance abuse, 10 were mothers ($n = 10; 76.92\%$) and 5 were fathers ($n = 5; 62.50\%$).

![Figure 2. History of substance abuse among caregivers.](image)

Mental health (Figure 3). A little over half of the adult FLS participants indicated history of mental health problems. Information on this item was available for 17
caregivers \( (n = 17) \). Nine reported having a current or past mental health disorder \( (n = 9; 52.94\%) \), and eight reported no mental health issues \( (n = 8; 47.06\%) \). All of the individuals who noted mental health issues were female \( (n = 9) \); thus, 69.23\% of the adult female participants were identified as having mental health challenges.

![Bar chart](image)

**Figure 3.** Participants identified with mental health disorders.

*Legal problems* (Figure 4). On the referral form provided by CWS, this statement appears, "Involvement with probation, parole, or recent incarceration." In contrast to some of the other statements on the form, which ask if a person has "ever" been in substance abuse treatment or had a mental health disorder, the question regarding legal involvement appears somewhat ambiguous and may not reflect the true nature of the participants' involvement with the criminal justice system. To this statement, five females \( (n = 5) \) and three males \( (n = 3) \) indicated they had legal problems (38.46 and 60.00\% of the total female and male responses, respectively). In sum, 44.44\% of adult participants indicated involvement with probation, parole, or recent incarceration.
Limited support (Figure 5). Perceived level of caregiver social support was found in several places in participant case files. CWS workers indicated whether they believed parents to have limited support on referral forms. Of the 17 notations made by CWS workers regarding social support, 9 (n = 9; 60.00%) caregivers were believed to have sufficient social support and 6 to have limited support (n = 6; 40.00%). Of those indicated as having limited support, five were females (n = 5; 45.46%) and one, male (n = 1; 25.00%).

Figure 5. Report of limited caregiver social support.
Family violence (Figure 6). Reports of family violence include six positive (n = 6; 42.86%) and five negative (n = 5; 35.72%) responses. One response was marked "unsure" (n = 1; 7.14%) for family violence, and in two families checkboxes were left blank (n = 2; 14.29%). The researcher eliminated duplicate responses for families in which both partners participated in FLS; therefore, this evaluation includes responses for families only with no breakdown by gender.

![Bar chart showing reports of family violence among program participants.]

Figure 6. Reports of family violence among program participants.

CWS and Caregiver Concerns

CWS concerns about caregivers (Figure 7). Child Welfare Services workers had the opportunity to indicate concerns regarding parents and children on the referral form. In three instances, workers made no comments. Most often, concerns recorded by CWS regarding caregivers related to lack of parenting skills and emotional and mental health issues (four responses each). This was followed by disciplinary problems and lack of basic living skills (three and two responses, respectively). Other concerns were lack of bonding between one parent-child dyad, desire for ideas for family leisure activities, and additional parenting support for a single parent, as well as for an adolescent parent. Still
other concerns related to limited social support, poor family functioning, and history of
caregiver childhood maltreatment.

*CWS concerns about children* (Figure 7). Aggressive, acting out, and disruptive
behaviors were the most-often recorded concerns about children. In addition, two
children were identified as clingy, crying, and “needy.” Other issues raised about children
were lack of attachment, parentification, and sibling rivalry.

![Bar chart showing top three CWS concerns about caregivers and children.](image)

*Figure 7.* Top three CWS concerns about caregivers and children.

*Parent goals.* Parents completing the Partnership Plan indicated their personal and
family goals. Ten of 21 caregivers responded that their primary goal was to reunify with
their children\(^4\) or keep their families together. The rest of the responses related to family
functioning and ranged from moving into appropriate housing, building a bond with their
children, stabilizing the family, improving communication, and developing family

\(^4\) These forms were typically completed months before participants enrolled in Family Life Skills. By the
time families began FLS, most children had been returned home.
routines. One individual’s response sums up what many caregivers alluded to, “Doing what we need to do for our family.”

**Intent to Participate.** Additionally, caregivers completed the Intent to Participate, which asks the participant to rate her/his skill level in several areas. Figure 8 exhibits the results of parental responses in areas related to Phase II of FLS instruction and those most pertinent to this evaluation: leisure time/activities with children, problem-solving, social support, and parenting skills. Of these skill sets, parents reported feeling knowledgeable about developing social networks ($n = 8; 50.00\%$). The majority believed they had adequate parenting skills ($n = 10; 55.56\%$). Areas most identified as needing more training were providing leisure activities for their children ($n = 7; 41.18\%$) and problem solving ($n = 7; 43.75\%$).

![Figure 8: Responses to key items on the Intent to Participate.](image)

**Home Visits**

Number of home visits to participating families ranged from 4 to 14 ($M = 8.36$). Absences, no shows, or need to reschedule occurred between zero to five times per
family \((M = 1.79)\). Progress notes were obtained from participant case files, and content analysis was done in order to identify emergent themes. The researcher coded for themes related to the constructs of the AAPI-2 (i.e., developmentally appropriate expectations, empathic awareness, appropriate use of non-abusive forms of discipline, appropriate parent-child roles, and beliefs about child empowerment and independence). It was expected that parenting attitudes and behaviors according to these constructs would improve over the course of FLS participation.

Emergent Themes

Expectations. In analyzing the data for this study, the researcher coded expectations as appropriate when caregivers discussed concerns about child behaviors that were out-of-sync for their developmental level. Responses were considered inappropriate when concerns over more typical behaviors were expressed or parents were unsure how to deal age-appropriate behaviors. As Figure 9 shows, an overall shift occurred in parental attitudes toward more appropriate developmental expectations during FLS participation. However, the construct of appropriateness of expectations is somewhat difficult to determine in this sample of at-risk families, as many of the children in this study appeared to have developmental delays of a variety of sorts.
For example, in one family, concern was noted regarding a 4-year-old who was not toilet trained. In itself, it is appropriate to expect a child of four to be toilet trained; yet, it is not unusual for children in out-of-home care to experience developmental setbacks. The home visitor did not report being overly concerned with the toilet training issue, as there were other more worrisome issues with which to deal, such as the child’s lack of attachment, acting out behaviors, and nightmares. Although the child’s mother initially had difficulty with the concept of floortime, she was willing to learn and began using the technique at and between visits. After the fourth visit, the HV reported that parent-child interactions had “greatly improved,” and the child was no longer acting out. Still, toileting habits were not mentioned beyond the first home visit.

In another family, the mother had difficulty engaging her 2- and 4-year-old children in floortime. On one occasion, the mother allowed the older child to choose the activities,

---

5 Since not all constructs are noted for each visit, for this and the next four figures, numbers of reported incidents reflect only instances when home visitors commented on related items.
but the child kept choosing games with rules and subsequently became angry and aggressive when his younger brother did not play by the rules. The mother in this situation did not provide more suitable choices or limits that would benefit both children, nor did she attempt to teach the older child to have patience with the younger child’s developmental limitations. Therefore, in this case, the researcher coded the mother’s behaviors as exhibiting inappropriate expectations. Since she dropped out of FLS after having only three joint parent-child sessions, no progress was noted.

In yet another family, the home visitor reported in each of the first three sessions that the parents were concerned about their 4-year-old son not sharing with his younger sibling or his peers at school. The researcher coded this matter as an appropriate developmental expectation; still, the question arises, given the situation in which the child had been involved, would expecting the child to share be appropriate or inappropriate. The case notes do not give a background of the child’s history prior to, or during removal from his home, or time spent in foster care. More importantly, the researcher ponders the idea of allowing this child, or any child for that matter, to have his/her personal boundaries recognized and respected. These issues are not addressed in FLS progress notes.

*Empathic awareness.* The AAPI-2 connects empathic awareness to parental beliefs and behaviors about the value and respect given to children and their needs. When caregivers exercise empathy toward children, they listen to, comfort, support, and accept them for the individuals they are. According to the AAPI-2, low levels of empathy are indicated when parents lack knowledge of normal child development, lack
communication with children, fear spoiling children, and believe that children must “be good” and “act right” (Bavolek & Keene, 1999). Therefore, when coding for empathy, the researcher primarily explored caregiver reactions to the floortime intervention because parental empathy is a key component in being able to engage in child-directed play. As was expected, parental empathic awareness improved over the duration of participation in the Family Life Skills program as shown in Figure 10.

![Figure 10. Caregiver empathic awareness.](image)

During the first three visits, home visitors generally recorded inappropriate (or lack of) empathic responses in about two of three cases. Examples typically involved parents who had difficulty feeling comfortable with floortime and were more controlling and directive of the children. In several cases, parents found interacting with their children difficult, especially during child-directed play. One excellent example of being unable to take the child’s perspective that surfaced early on was one mother who described her distaste for changing her 10-month-old son’s diapers. Because the child smiled during
diaper changes, the mother believed him to become sexually aroused when she performed this activity.

It is interesting that during each family’s fourth home visit, most HV comments regarding parental empathic awareness were regarded as negative or inappropriate. Parents continued to be rather controlling and, in at least one instance, “harsh and rude.” Parents often had trouble giving up control of floortime activities and expected children to play and behave “right.” In addition, home visitors provided several examples of parents using disciplinary practices that seemed inappropriate for the situation, whereas, parents could have used a more empathic parenting style to take advantage of those teachable moments. One mother, for instance, continued using time-outs for minor sibling disagreements and rule infractions instead of talking to her children or teaching them to be more proactive in resolving their conflicts.

By the sixth visit, parents began to display much higher levels of empathy for their children. In fact, of eight recorded responses that relate to empathy during the sixth visit, the researcher considered seven appropriate. By the sixth visit, parents tended to engage more easily in child-directed play, became more attuned to children’s cues, and more often provided positive and patient feedback to them. Improvements were also beginning to be seen in the children by the sixth visit, and at times before, as when the home visitor recorded the 2-year-old in one family, initially described as “crying and needy,” no longer demanded all of his mother’s time and attention.

The trend toward increasing parental empathy continued through the tenth visit, by which time most families had completed the program. Of those who remained at the
twelfth visit, less empathic responses reemerged, as did reversals in all the other constructs evaluated herein. It must be noted, however, that in each of the three families that remained after the eleventh visit, home visitors recorded other, more serious, long-term problems such as mental health problems, substance abuse relapse, attachment disorder, and conflicted parental relationships.

**Discipline.** The corresponding AAPI-2 construct for discipline, as used in this study, is “Belief in the Value of Corporal Punishment” (Bavolek & Keene, 2001). Given that participants of FLS had open CWS cases, the researcher did not expect to find much in the way of beliefs about corporal punishment in the case files. In fact, only one of the participating families had an initial CWS report of physical abuse. Indeed, in no other case was physical punishment mentioned in referrals or progress notes. Therefore, the researcher focused on appropriateness and inappropriateness of disciplinary techniques utilized by caregivers.

*Figure 11.* Disciplinary styles.
When analyzing the data, a very clear pattern emerged showing that parents strongly leaned toward harsher or more inappropriate discipline at the beginning of FLS participation than when they completed the program (Figure 11). Typical examples of inappropriate disciplinary practices seen at the beginning of Family Life Skills participation were difficulties in consistently setting limits on children’s behaviors and, in one case, using time-out for minor disagreements or infractions of rules.

By the third visit, most notes regarding disciplinary behaviors seem more appropriate and parents were more often successfully using a variety of disciplinary practices such as redirection, talking to children, and problem solving. Several instances were recorded where older children were given time-out for aggressive behaviors and then allowed to return to floortime activities after they calmed themselves.

Again, as with other constructs, in two families there seemed to be more wavering back and forth. While some progress was observed during the middle phase of the intervention, there was a regression to more inappropriate use of discipline after 12 visits. Such was the case when one father resorted to yelling, threatening the children with harsh punishments, and excessively using time-out in an attempt to gain control of the chaotic home environment and aggressive child behaviors. In yet another family, the mother was, at times, able to set appropriate limits and redirect her 1-year-old child; however, during her last visit, the HV noted that Mother stood her child in time-out facing a wall. The researcher deems this form of discipline inappropriate for the child’s age, regardless of his perceived offense, which was not mentioned.
Parent-child role reversals. The AAPI-2 (Bavolek & Keene, 2001) distinguishes caregivers low on this construct as those who expect the child to meet their needs as opposed to them meeting their children’s needs. They tend to believe that children are responsible for the happiness of the parent, while caregivers high on the construct of family roles tend to get their needs for comfort, support, and encouragement from their peers or other adult companions. In this study, there was little noted regarding this construct. In one case, a CWS worker mentioned on the referral form that a 6-year-old child was parentified. Other than this, this issue was not mentioned again in the participant’s case file.

In another case, the HV remarked that one divorced father allowed his 11-year-old daughter to take care of her 3-year-old sister. The pre-adolescent’s father did not take responsibility for his child’s behavior, stating instead that his sister had taught the child these behaviors while the children were in her care. In this case, the home visitor made no mention beyond the initial visit of how the family negotiated roles as they progressed in the FLS program. In both cases, overall results were positive, as parents learned how to interact more appropriately with their children, and both families successfully completed the program.

Power and independence. The last concept identified by the AAPI-2, and used in this program evaluation, is that of child empowerment and independence. Parents low on this construct tend to be inflexible and controlling, do not value corporate problem-solving that includes children, and may even consider a child’s independent thinking as disrespectful (Bavolek & Greene, 2005). Parents on the other end of the spectrum,
conversely, believe children should have a voice. They respect children’s opinions and feelings, strive to empower their children to make good choices, and allow them to have input into planning family activities and developing family rules.

In reviewing case files for this project, the researcher found few instances where child autonomy, empowerment, or independence was specifically noted. Since the technique of floortime requires the parent to follow the child’s interests, it lends itself to the development of autonomy in children. Thus, notations regarding control and capacity to engage in child-directed play, along with independent items, such as helping children engage in problem-solving activities, were included in this analysis of the construct of power and independence.

![Figure 12. Caregiver Beliefs about Children's Power and Independence.](image)

As with empathy, a clear pattern emerged when the researcher mapped individual responses together in order to view overall effects of the floortime intervention as used in the Family Life Skills program (Figure 12). In the first four sessions, parental responses indicated strong beliefs in parental control and child obedience. This was primarily seen
as parents had difficulty in following their children’s lead and insisting that children “follow the rules” or do things “right.” In the family where the mother interfered with her children’s small disputes, the mother exhibited little belief that the children could work out their own problems, and her interferences were coded inappropriate on the construct of power-independence. Likewise, forcing a child to share, as occurred in another family, is this is a way of saying to the child that he has no personal boundaries or rights – he has no personal power and must only do what he is told. This was also an example of inappropriate beliefs in child power-independence.

By the sixth visits, an apparent shift was observed, with caregivers more easily allowing children to lead during floortime and to engage in other empowering activities. In most instances, FLS case notes relate to parent-child interactions during floortime and the researcher was able to infer caregiver improvements in the areas of child power and independence by comparing comments recorded during early sessions, to those made later. For example, after the first visit to one family, the home visitor wrote,

“Client (mother) was resentful, reported she does not like to be corrected. Children played well with stepfather. Mother sat with us but was reluctant to play. Client criticized some of what the children were doing... Explained ‘Floor Time’ is child-direct (sic). Children get to say how they want to play with toys. Client appeared to be troubled by this. Client report (sic) she again did not like to be told what to do.”

After the family’s fourth visit, the progress note states, “Client (mother) appeared to be relaxed. Client followed ‘Floor Time’ direction and was trying to allow the children to
be in control. Not easy for her to give up control.” Even more progress was reported after
the seventh visit, as evidenced by the home visitor’s description that the mother had been
able to engage in “bonding exercises” and that she was now using more “positive
language” as she played with the children. Thus, although it was not specifically stated
that the parent’s beliefs about children’s power and independence changed during
participation in FLS, the researcher coded caregiver behavior primarily according to
willingness to engage in the process and follow her children’s lead during floortime.

Termination

Successful completions. On most occasions, home visitors noted that termination of
services was due to completion of the program (n = 12; 85.71%); however, concerns
regarding all but six of the families were recorded or observed. For those successfully
completing with no additional concerns noted, discharge statements consisted of
observations as “The family was successful in completing parenting portion of the Life
Skills Program” and “Parents learned to successfully set limits with child’s
tantrums...appeared warm, respectful, and enjoyable.” In one case, the home visitor
recorded that after the fourth visit the parent and child were interacting well with each
other, and the child had not displayed aggressive behavior since changing preschools
(reported at the fourth visit). In addition, this participant reported that the home visits and
learning about child-directed play “greatly improved” her relationship with her child.

Program completions, but problems remain. In other instances, completions are
indicated but problems are recorded. Substance abuse relapses were recorded in four
cases and was the most common challenge that arose during program participation. In
two cases, relapse caused immediate termination of FLS services. One mother, however, was allowed to continue her FLS program after a five-month suspension. On her final visit, the home visitor recorded the mother “behaved appropriately with her son and was able to redirect his behavior as needed.”

Moreover, when the father in another family had a relapse, the mother and children separated from him. Up until the separation, the visits were somewhat disconcerting to the home visitor who noted that disruptions interfered with progress and the 4-year-old continued acting out in very aggressive ways toward his mother. In addition, the father tended to engage in negative disciplinary actions toward the children and blame-shifting behaviors toward the mother. After the couple’s separation, interactions among the mother and children improved a great deal in a short time. The mother terminated services when she and the children moved to a neighboring county.

In another case that was closed by CWS, the HV reported that home visits were interrupted when the mother began experiencing problems related to her pregnancy. She was hospitalized on four occasions and eventually had surgery. At the same time, this mother’s partner had a substance abuse relapse, committed a crime, and was incarcerated. Recommendations given by the home visitor on the Closing Summary included “family counseling when Father is out of jail; child (a 6-year-old female) needs support in dealing with all of the family changes and transitions.”

Problems remain. As was previously discussed, there were three families that received 12 or more visits wherein some progress was seen during the middle sessions, but at the culmination of services, reversals in progress were observed. One of these
families was a blended family in which the mother was pregnant with her fifth child. She had two older children who did not live with her and her husband. In this case, the mother seemed somewhat detached from the process, on one occasion arriving late and on another leaving early. Both parents initially had difficulty letting the children take the lead and have control over play during floortime. Improvements were being made, though the concept of child-directed play still seemed a challenge. When the mother delivered her child one month early, the parents and home visitor attempted to monitor the younger children for adjustment issues. Within one month, however, the home environment became much more chaotic and quickly decomposed with the father resorting to much more negative parenting behaviors. On the Closing Summary, the HV indicated,

"Once the baby (third child) was in the home, the home environment became chaotic and the children were acting out. The parents became defensive and confrontational and this impeded our ability to support and use positive parenting skills and techniques. Thus, the goals of supporting positive parent-child interactions and good family communication were not met."

Records, furthermore, indicate that the father in this family was suspected of have a substance abuse relapse. The family moved shortly thereafter, effectively terminating services.

In yet another family, the mother generally remained self-absorbed throughout the intervention. She had a diagnosis of Bipolar Disorder and stated during her second home visit that she was on medication and getting counseling once a week. However, this
single mother continued experiencing problems regulating her thoughts and emotions. During floortime, she tended to focus more on her personal issues and things that were going on with her older child (not participating in FLS) than on her 1-year-old. The home visitor recorded on the Closing Summary, among other things, that the participant had met standards for graduation from the FLS program, but “she still appears to need improvement in her parenting skills and abilities.” This challenge became more evident as her youngest child transitioned from infancy to toddlerhood, and the mother continued having trouble with instability and making appropriate decisions. Interestingly, this mother terminated her FLS services, claiming that she already had knowledge of parenting.
Chapter 5

DISCUSSION

Introduction

Involvement with Child Welfare Services, by its very nature, is evidence of at-risk conditions in a family. It is for this reason that CWS often offers a variety of family support services to families entering the system. A common approach taken by CWS is to conduct home visits; however, the caseloads of CWS workers are very high and time is limited. Thus, there has been a need to shift service delivery over to community-based agencies that offer specialized services on a longer-term basis. The Family Life Skills Home Visitation Partnership Plan is one such collaborative effort between Yolo County Child Welfare Services and two community agencies whereby at-risk conditions of caregivers and children can be addressed on a longer-term, more intensive, individualized basis. This report is a product of the evaluation of the parenting education phase of the program, Family Life Skills (FLS).

Discussion of the Findings

Preliminary effectiveness of FLS. The purpose of this project was to determine if providing parenting education through the model of floortime during home visits would improve parenting attitudes and behaviors in relation to the constructs measured by the AAPI-2 (i.e., developmentally appropriate expectations, empathic awareness, beliefs in alternatives to corporal punishment, family roles, and child power and independence). The preliminary findings suggest that for caregivers with open CWS cases, there may be a positive association between parenting instruction during participation in Family Life
Skills and improvements in the areas of developmentally appropriate expectations, empathic awareness and responsiveness, appropriate use of discipline, and beliefs in child empowerment and independence. Not enough information is recorded in FLS case files to determine whether parent-child roles improved in any way during FLS participation.

Challenges in the program evaluation. Although initial evaluation of FLS suggests that the program may be effective in enhancing parenting knowledge, attitudes, and skills, results were difficult to determine because, on the one hand, there was much missing information in the case files, and, on the other, many family problems surfaced and were recorded throughout case notes. By using a mind-mapping technique (Buzan, 2008) with regard to the variables chosen for evaluation, patterns were more easily detected and improvements in parent-child interactions generally began to emerge around the third home visit. By the sixth visit, almost all parent-child interactions were coded as appropriate and the trend toward more nurturing parenting practices continued for most caregivers until they completed the program. In only three families that had 12 or more visits, was regression to more negative parenting practices seen.

Integration of literature. Gomby (2005) states that the most effective programs are those where parents have the ability to opt-in before serious problems develop. Given the high levels of caregiver substance abuse, mental health problems, criminal justice involvement, and family violence, the fact that problems developed during FLS participation is not unusual. Often, evaluations of home visitation services result in mixed results (Bilukha, et al., 2005; Casanueva, et al., 2008; Krysik, et al., 2007; McElroy & Rodriguez, 2008; Olds, et al., 2007; Weiss & Klein, 2006). One of the inherent
challenges of offering services exclusively to high-risk families is the fact that home visiting programs may be ill-prepared to adequately serve them (Gomby, 2005). In fact, Gomby (2005) reports that the three most troubling family problems that affect home visitation effectiveness are domestic violence (intimate partner violence), substance abuse, and mental health issues—all evident in the families in this study.

In their studies of larger home visitation programs based on the Healthy Families America model, researchers have reported that home visitors are often not trained, or are not comfortable, in the assessment of or addressing high-risk family situations (Duggan, et al., 2004; Duggan, et al., 2007; Gomby, 2005; Layzer, Goodson, Bernstein, & Price, 2001). As Gomby (2005) says, it is imperative that home visitors receive training and feel comfortable dealing with issues related to substance abuse, intimate partner violence, and mental health issues for “these are most likely to stymie progress for parents and to harm children” (p. 43). Even though the FLS home visitors represented in this study all have experience working with at-risk populations, differences in approach to FLS instruction appear to correspond with training and experience types. There is no indication that any training was provided to home visitors for the period reviewed in this study, either in the floortime model or in dealing with serious family issues. Trainings that have existed for FLS staff have primarily focused only on child development.

Analysis of FLS program challenges. One line of reasoning for taking a more narrow approach is that Family Life Skills is usually only one program offered to families involved with Child Welfare. Other programs offered on an as needed basis to parents are anger management, intimate partner violence counseling, mental health assessments,
parenting classes, and substance abuse treatment. There are, however, flaws with this line of thinking, not the least of which is that not all parents require, nor are they offered, the range of services available. Another inherent problem is that people are quite capable of doing all of the required tasks and still not make the internal shifts necessary for long-term recovery. For example, as was stated in a previous chapter, the researcher teaches a parenting class and often hears parents who have open CWS cases describe their frustration at “jumping through all the hoops” that CWS sets before them and their dismay when their cases are prolonged and their children not immediately returned to their custody. Certainly, it seems the more services that parents can take advantage of, the more likely it is they will make that internal shift, but many difficulties abound in the delivery of services, the breadth of which are out of the scope of this study.

Relevant to this study, however, is that there is no formal assessment process in the FLS program to suggest that home visitors understand the full range of issues with which a family is challenged. Initial referral forms provide only very basic information. For example, one question is posed: “Ever received, or currently receiving mental health or psychiatric assistance?” Checkboxes then offer responses for “yes,” “no,” and “unsure.” This box was marked “yes” for 9 of the 13 adult female participants and was not even mentioned for males. Of those nine women, only four remarks were made about three mothers that related concerns about mental health. In one case the CWS worker indicated the mother had mental health issues and commented, “Unstable emotional control; can be overwhelmed; fear of discipline style,” but there are no case notes that indicate the home visitor ever talked about mental health issues with the mother.
There was only one case where a mother reported a mental health disorder. She had bipolar disorder and medication issues were occasionally noted. The HV recorded on case notes that this mother often had difficulty staying on topic, being able to follow her child’s lead, and tended to “jump” from one toy/subject to another. The mother often reverted to talking about her personal issues and the abuses she experienced as a child. The HV, a gifted child development professional, attempted to keep the mother on track with the model of floortime, perhaps reasoning from the narrow perspective that the mother was getting psychiatric treatment and therapy elsewhere. Yet, if engaging in floortime ultimately triggered difficult memories for the mother, one wonders at its benefit if the HV simply directed the mother back to the floortime exercise instead of having the freedom and clinical skills to help the mother process some of her difficulties.

**Implications of the Findings**

*Generalizability issues and importance of FLS.* Due to the qualitative nature of this project, the small sample size, lack of random sampling, and lack of a control group, the results cannot be generalizable, and the findings have significance only to Yolo County CWS and CommuniCare Health Centers/Family Life Skills program. FLS is an innovative program in its purpose and scope. Few studies exist exploring the effectiveness of using floortime with typically developing children as a parenting enhancement intervention, and this researcher found no studies regarding its use as an instructional method with families involved with Child Welfare Services. With over 3.3 million reports of child maltreatment pouring into CWS offices each year (DHHS, 2008), it is of the utmost importance to explore new programs providing direct-service to
families involved with CWS to determine best practices in the intervention and prevention of child maltreatment.

Importance of small effects. When considering effectiveness of home visitation programs, it is necessary to evaluate the small positive and mixed effects reported by many programs (Gomby, 2005; Kessler, Nixon, & Nelson, 2008; Layzer, et al., 2001). Researchers determined that even small effects are beneficial for several reasons. First, since most programs utilize self-report measures, there may be discrepancies between self-reports and real-world behaviors. That is, just because someone does well or poorly on a test, it does not mean that the program was or was not a worthwhile investment. Discrepancies may also show up in the differences between observed and reported behaviors, as noted in Duggan, et al. (2004) and Duggan, et al. (2007) where home visitors generally failed to either observe or report high-risk situations and parenting behaviors.

Fade-out and sleeper effects. Gomby (2005) notes that fade-out and sleeper effects sometimes explain the differences between short- and long-term attitudinal and behavioral shifts, with apparent short-term effects either losing or gaining momentum over time. Fade-out effects are seen when participants lose the effects of the intervention, while sleeper effects are most often seen as a cumulative effect of continued services that extend beyond the home visitation program. Since the FLS program does not currently incorporate standardized measures, a program evaluation process by the participants, or a way to follow-up with participants later, analysis of the effectiveness of the program rests
solely on forms and notes generated at the time of participation, further complicating an accurate analysis of the implications of the FLS program evaluation.

Limitations of the Study

Several problematic areas came to light during this evaluation, not the least of which is that FLS program administrators and home visitors did not adhere to the Family Life Skills Partnership Plan contract agreed upon by the agency and the county with regard to the use of a variety of research instruments. There was also lack of consistency in amount of information provided on both CWS and agency forms, and, in many cases, the lack of the forms themselves. Another issue is that often FLS services were offered so late in the Family Reunification process that services were only provided for a very short time before the case was closed. In fact, this applied to 4 of the 14 families whose case files were included in the evaluation and 2 of the 4 ended on a somewhat negative note.

Another challenge that must be mentioned is that there are no components built into FLS that allow for follow-up with families who complete the program to determine if there are any long-term effects. Given the high-risk nature of the sample and their involvement with CWS, it would be worthwhile to determine which, if any, services made a difference in reducing recidivism rates. As was seen in this evaluation, substance abuse relapse in several families occurred, and as more time passed while a family was receiving FLS services, more troubling difficulties emerged.

Recommendations for FLS Improvement

Contract compliance. The researcher recommends that the agency examine the terms of the FLS contract and either become compliant in the use of the measures specified or
negotiate with the county alternative ways to collect the desired data. Some of the measures listed in the contract are readily accessible and easy to score, whereas others must be purchased. As for the AAPI-2, it might prove to be one of the most beneficial measures to use as a pre- and post-test measure of the effectiveness of FLS because the constructs it evaluates resonate with the principles and goals of FLS. As mentioned previously, the other measures would provide good information (e.g., screening for maternal depression, substance abuse, and levels of family conflict); however, a facilitator trained in conducting biopsychosocial assessments would certainly be able to gather as much information, if not more, by using skillfully constructed open-ended questionnaires. The important thing is that future practice in effect reflects the contract.

**Staff training.** A more standardized way of approaching home visitor training and program implementation might also prove useful. During the time reflected in this program evaluation, no training program for the home visitation program was available. Fortunately, not many families experienced a change of HVs during their participation, still there were four different home visitors and differences in approach are clearly visible upon examination of case files. Though professional training (having a professional degree and specialized training) has not been clearly identified as a factor in successful home visitation programs\(^6\) (Layzer, et al., 2001), for consistent service delivery, high-

---

\(^6\) Professional status of home visitors made little difference in most of the studies analyzed by Layzer, et al. (2006) with the exceptions that use of professionals increased the positive long-term effects when parents had mental health problems, families had children with developmental delays or behavioral problems, and in programs centered on parent self-development.
quality staff training is a must. At the very least, the researcher recommends training in the DIR®/Floortime™ model to improve knowledge of the model and uniformity in instructional methods. This sentiment was echoed by the current home visitor who stated, “I would like to have been acquainted with all of the necessary paperwork and what it all meant before seeing clients. I would like to have observed several floor time sessions before attempting them on my own. I think it’s important to be able to ease into this position with the guidance of a trained FLS reporter to set the example for what a positive session looks like” (R. Pryor, personal communication, April 6, 2009).

*Service delivery.* In addition, using either a commercially-prepared curriculum or developing one would be beneficial in assisting home visitors in presenting materials in a consistent, sequential fashion, while maintaining enough flexibility for individualized attention as the need arises. Since many parents involved with Family Life Skills revealed previous or ongoing challenges of a variety of sorts, the Nurturing Parenting programs might prove useful, as focus is on the family as a system and both caregiver and child issues are considered. Another option might be to use a curriculum based on the model of filial play therapy since instruction in floortime is closely connected to this form of child and family therapy.

Whatever specific curriculum is decided upon, it would be beneficial to add video microanalysis and feedback (VMF) to the floortime sessions. VMF has emerged as an effective way to give caregivers a visual perspective of their own parenting behaviors, as well as how their behaviors influence their children (Biringen, 2000; Hoffman, et al., 2006; Oppenheim & Koren-Karie, 2002; Schechter, et al., 2006; Solomon, et al., 2007).
Additionally, videos can be used by facilitators and future program evaluators to code for behaviors correlated with the development of secure attachments and reduction of abusive and neglectful parenting practices (Dozier, et al., 2006; Duggan, et al., 2004; Laranjo, et al., 2008; Lok & McMahon, 2006; Moehler, Biringen, & Poustka, 2007).

**Participant evaluations and follow-up.** Finally, the researcher recommends that agency directors develop a method to evaluate the program periodically. Currently, there are quarterly reports sent in by the agency to Child Welfare Services. Quarterly reports give such information as how many families participated in and completed the program, as well as challenges and accomplishments of the program. It would be beneficial to allow participating caregivers to provide input in the program evaluation process through post-intervention interviews, questionnaires, or both. Periodic follow-up using a longitudinal approach would also inform program administrators as to the program’s long-term effectiveness. Follow-up parent interviews and/or home visits could be conducted quarterly for up to one year and corresponding case files from CWS reviewed after a year to ascertain whether additional maltreatment allegations had been filed after completion of the FLS intervention. While expense might be an inhibiting factor to a longitudinal study, cost effectiveness of intervening early must be weighed against current high recidivism rates (DHHS, 2008; Wang & Holton, 2007).

**Implications for Social Work Practice**

Child maltreatment is a very difficult problem that affects not only children, but also has an impact on families, communities, society as a whole, in addition to future generations. The costs to all involved are high. Children, of course, withstand the worst
effects of maltreatment through compromised physical, mental, emotional, cognitive, and relational health (Wang & Holton, 2007). As the researcher has explained throughout this thesis/project, child maltreatment has the potential to influence development and child attachment systems in ways that often leave children susceptible to repeating maladaptive coping patterns throughout the lifespan. Maltreating families are often devastated by the removal of children, and communities are affected by increased behavioral problems and risk-taking activities of maltreated children. Furthermore, as Wang and Holton (2007) report, the estimated annual direct/indirect costs associated with child maltreatment are enormous and were estimated at approximately $103.8 billion in 2007.

While maltreated children entering the Child Welfare System are at added risk for negative outcomes, resilience is possible and can be developed through appropriate interventions targeted at addressing the variety of factors that put children and families at-risk. The Family Life Skills Home Visitation program is a novel and promising approach to parent education that provides instruction in floortime methods during home visits to families involved with CWS. As presented, FLS has the capacity to enhance parent-child interactions and bonds, and improve parental knowledge of child development, increase empathic awareness, help parents choose more nurturing disciplinary practices, and shift parenting practices overall to allow for more child empowerment and independence.
REFERENCES


