

IMPLEMENTATION AND EVALUATION OF A PSYCHOEDUCATIONAL PROGRAM FOR
PARENTS RECENTLY REUNIFIED WITH THEIR CHILDREN: A CASE STUDY

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

THE GRADUATE SCHOOL OF APPLIED AND PROFESSIONAL PSYCHOLOGY

OF

RUTGERS,

THE STATE UNIVERSITY OF NEW JERSEY

BY

VERONIQUE NICOLE LEE

IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

DOCTOR OF PSYCHOLOGY

NEW BRUNSWICK, NEW JERSEY

OCTOBER 2010

APPROVED:

Charles Maher, Psy.D.

Nancy Boyd-Franklin, Ph.D.

DEAN:

Stanley B. Messer, Ph.D.

ABSTRACT

This dissertation focuses on the process of designing, implementing and evaluating a parenting program for single parents with a history of mental illness who have been separated from their children, within the context of a residence at a human services agency in an urban setting. Maher's program planning and evaluation framework and a case study approach were used to facilitate the process. Principles of attachment theory informed the curriculum created for the program. This dissertation was conducted with an intention to contribute to the attachment literature and to expand knowledge about the needs of parents with a history of mental illness who have lost custody of their children. Maher's program planning and evaluation framework consists of four phases: clarification, design, implementation and evaluation. During the Clarification Phase, an assessment of the parents' needs and the relevant context was conducted. The needs assessment revealed that parents at the residence had significant past histories of trauma and poor parenting that negatively affected their skills as parents. Additionally, it was determined that many parents struggled to connect emotionally with their children and to provide appropriate discipline. A program design was then created based on the needs identified in the Clarification Phase. The program was entitled the Attachment Based Parenting Program and consisted of a psychoeducation group designed to teach parents skills to improve attachment with their children and to provide appropriate discipline. A description of the program and its implementation is further detailed in this dissertation. The program was implemented over the course of 12 weeks in the Fall of 2008 and involved 10 parents. Following the program implementation, an evaluation was conducted. Results of the evaluation revealed that the program provided some value to

the participants: (a) parents were able to process their own history; (b) parents were able to better understand ways in which prior traumas affected their ability to connect with their children; and (c) parents learned new skills to improve their connection to their children. Constraints of the dissertation are noted and recommendations are provided for future design and implementation of the program.

ACKNOWLEDGEMENTS

As I near the end of my training at GSAPP I am reminded of all the individuals who supported me along the way. I would like to thank my committee chair, Dr. Charles Maher for his guidance throughout this dissertation process. The skills and knowledge I gained from his course were instrumental in aiding me throughout the dissertation process and will serve me well in my future career. Without his support, guidance and knowledge this dissertation would not have been possible.

I would also like to thank Dr. Nancy Boyd-Franklin who not only served as a dissertation committee member, but also as my advisor throughout my time at GSAPP. Her teaching, guidance and example have helped shape my professional identity and her feedback and support throughout the dissertation process has helped to keep me motivated.

Additionally, I would like to thank Sylvia Krieger, Suzanne Baranello and Alicia Piccone for their dedication to the GSAPP community. Their hard work and support has helped me through every step of my journey at GSAPP.

I would especially like to thank the staff at the community organization that is the focus of this dissertation for the encouragement, supervision and support I received throughout my years as a practicum student at their organization as well as throughout this dissertation process. The skills I have learned while working at this organization have served me well as I continue my training. My time at this organization has furthered my commitment to serving underserved populations. I would also like to thank the parents who participated in the program for their willingness to share their stories and their openness to the work we did in the group.

Lastly, I would like to thank my amazing friends and family for their emotional support, encouragement and understanding. Thank you for cheering me on, for listening to me complain for providing me with advice and for being there when I needed you. I would especially like to thank my husband for the many sacrifices he has made to support me in my journey through graduate school and for encouraging and pushing me when I needed it. I would like to thank my parents for their hard work, their dedication to our family and their unwavering support throughout my life.

TABLE OF CONTENTS

	PAGE
ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iv
LIST OF TABLES	xx
LIST OF FIGURES.....	xxiii
CHAPTER	
I. INTRODUCTION AND OVERVIEW.....	1
Abstract	1
Introduction	1
Relevance of Dissertation Project	2
Overview of Program Design, Implementation and Evaluation Framework.....	4
Description of the Dissertation Process.....	5
Summary.....	9
II. REVIEW OF LITERATURE.....	10
Abstract	10
Introduction	10
Parents with Mental Illness	11
Attachment.....	14
Intergenerational Transmission of Attachment Styles	19
Attachment-based Programs.....	21
Child Maltreatment	25

Foster Care.....	27
Family Reunification.....	31
Play Therapy.....	34
Filial Therapy.....	35
Family Theraplay	37
Parent Child Interaction Therapy	38
Summary.....	41
 III. METHODS OF INVESTIGATION	43
Abstract	43
The Four Phases of the Program Design and Evaluation Framework .	43
Clarification Phase	44
Identifying the Target Population.....	44
Needs Assessment	45
Context Assessment.....	46
Design Phase	47
Implementation Phase.....	48
Evaluation Phase	49
Gaining Access to the organization.....	50
Entry into the Organization.....	50
Introduction to the Residential Facility	51
Summary.....	52
 IV. CLARIFICATION PHASE.....	54
Abstract	54

Introductory Information	54
Client	54
Organization.....	55
Target Population Description	56
Family Characteristics	56
Size/Frequency	56
Age of Children	56
Ethnic Background	57
Parent Characteristics	57
Demographics	57
Psychological Functioning	57
Needs Assessment.....	59
Needs Assessment Domains	59
Protocol I.....	60
Domain: Psychological Concerns of Parents	60
Data Collection Variables	60
Data Collection Methods, Instruments, Procedures.....	60
Methods and Procedures for Data Analysis and Interpretation	61
Guidelines for Communication and use of Needs Assessment Information	62
Roles, Responsibilities, Timelines	62

Protocol II.....	63
Domain: Psychological Concerns of Parents	63
Data Collection Variables.....	63
Protocol III	63
Domain: Psychological Concerns of Parents	63
Data Collection Variables.....	63
Protocol IV	64
Domain: Parenting Skills.....	64
Data Collection Variables.....	64
Protocol V	64
Domain: Parenting Skills.....	64
Data Collection Variables.....	64
Protocol VI.....	65
Domain: Parenting Skills.....	65
Data Collection Variables.....	65
Protocol VII.....	65
Domain: Attachment	65
Data Collection Variables.....	65
Protocol VIII	66
Domain: Attachment	66
Data Collection Variables.....	66
Protocol IX.....	66
Domain: Attachment	66

Data Collection Variables.....	66
Protocol X	67
Domain: Attachment.....	67
Data Collection Variables.....	67
Needs Assessment Results	68
Context Assessment	75
Purpose of Context Assessment	75
Contextual Variables	75
Ability	75
Human Resources	75
Technological/Informational Resources	77
Physical Resources.....	77
Financial Resources	77
Temporal Resources.....	77
Values	78
Ideas	78
Circumstances	79
Timing.....	80
Obligations	80
Resistance.....	81
Yield.....	81
Summary.....	82
V. PROGRAM DESIGN PHASE	83

Abstract	83
Statement of Program Purpose and Goals	83
Purpose	83
Goals	84
Eligibility Standards and Criteria.....	85
Policies Statement	86
Inventory and Components to Program Design.....	86
Component I: Orientation of Staff to Parenting Group	86
Methods.....	87
Technique	87
Procedure	87
Materials.....	87
Equipment	87
Facilities	87
Incentives	88
Personnel	88
Sequencing of Activities	89
Component II: Recruitment of Parents to Participate in Program	89
Methods.....	89
Technique	89
Procedure	90
Materials.....	90
Equipment	90

Facilities	90
Incentives	90
Personnel.....	91
Sequencing of Activities	92
Component III: Parent Group	93
Methods.....	93
Technique.....	93
Procedure	93
Materials.....	93
Equipment	94
Facilities	94
Incentives	94
Personnel.....	95
Sequencing of Activities	96
Budget	97
Program Evaluation Plan.....	98
Protocol I.....	98
Program Evaluation Question 1	98
Data Collection Variables	98
Methods, Instruments, Procedures for Data Collection	98
Methods and Procedures for Data Analysis and	
Interpretation	99
Guidelines for Communicating Evaluation Results.....	100

Protocol II	100
Program Evaluation Question 2	100
Data Collection Variables	100
Methods, Instruments, Procedures for Data Collection	100
Methods and Procedures for Data Analysis and	
Interpretation	102
Guidelines for Communicating Evaluation Results.....	102
Protocol III	103
Program Evaluation Question 3	103
Data Collection Variables	103
Methods, Instruments, Procedures for Data Collection	103
Methods and Procedures for Data Analysis and	
Interpretation	105
Guidelines for Communicating Evaluation Results.....	105
Summary.....	105
 VI. DESCRIPTION OF PROGRAM IMPLEMENTATION	 106
Abstract	106
Introduction	106
Orientation of Staff to Parenting Group.....	107
Recruitment of Participants	107
Parenting Group	109
Finding a co-facilitator	110
Group Curriculum	111

Adult Attachment Interview.....	111
Circle of Security Project.....	112
The Compassion Workshop	113
Parent-Child Interaction Therapy	113
Group Sessions	115
Session 1	115
Session 2	118
Session 3	119
Session 4	121
Session 5	123
Session 6	125
Session 7	125
Session 8	126
Session 9	127
Session 10.....	130
Session 11.....	132
Session 12.....	134
Challenges to Group Implementation.....	135
Summary.....	136
VII. PROGRAM EVALUATION	137
Abstract	137
Title of Program Evaluated	137

Client, Relevant Stakeholders and Organization	137
Client	137
Other Relevant Stakeholders.....	138
Organization.....	139
Program Evaluation Needs and Relevant Context.....	139
Needs for Evaluation Services	139
Client Program Evaluation Needs	140
Context Assessment	140
Purpose of Context Assessment	140
Contextual Variables	141
Ability	141
Human Resources	141
Technological/Informational Resources	141
Physical Resources.....	141
Financial Resources	142
Temporal Resources.....	142
Values	142
Ideas	143
Circumstances	143
Timing	143
Obligations	144
Resistance.....	144
Yield.....	145

Placing Program in Evaluable Form	145
Program Design Elements	145
Component I: Orientation of Staff to Parenting Group	145
Component II: Recruitment of Parents to Participate in Program.....	146
Component III: Parenting Group.....	146
Summary.....	146
Program Evaluation Questions	147
Program Evaluation Protocols	148
Protocol I.....	148
Program Evaluation Question 1	148
Data Collection Variables	148
Methods, Instruments, Procedures for Data Collection	148
Methods and Procedures for Data Analysis and Interpretation	149
Program Evaluation Personnel, Responsibilities and Timelines	151
Summary of Results	152
Protocol II	153
Program Evaluation Question 2	153
Data Collection Variables	153
Methods, Instruments, Procedures for Data Collection	153
Methods and Procedures for Data Analysis and	

Interpretation	155
Program Evaluation Personnel, Responsibilities and	
Timelines	155
Summary of Results	156
Protocol III.....	160
Program Evaluation Question 3	160
Data Collection Variables	160
Methods, Instruments, Procedures for Data Collection	160
Methods and Procedures for Data Analysis and	
Interpretation	162
Program Evaluation Personnel, Responsibilities and	
Timelines	162
Summary of Results	163
SMART Goal 1	164
SMART Goal 2	165
SMART Goal 3	166
SMART Goal 4	169
SMART Goal 5	171
SMART Goal 6	172
SMART Goal 7	172
Guidelines for Communication and Use of Program	
Evaluation Results.....	175
Evaluation of the Program Evaluation	177

VIII. SUMMARY AND CONCLUSIONS ABOUT THE PROGRAM.....	178
Abstract	178
Needs Assessment.....	178
Group Design.....	179
Implementation of the Group.....	180
Challenges.....	183
Factors that Positively Affected Group Implementation.....	184
Evaluation.....	185
Evaluation Measures	185
Evaluation Results.....	186
Constraints of the Investigation	187
Recommendations.....	187
Summary.....	189
REFERENCES.....	191
APPENDICES	198
A. Target Population Interview Protocol	198
B. Interview Protocol for Needs Assessment.....	199
C. Attachment Based Parenting Program.....	201
D. Attachment Based Parenting Program Description for Parents.....	202
E. Parent Questionnaire.....	203
F. Program Implementation Checklist	205
G. Staff Reaction Survey.....	207
H. Follow Up Parent Survey	209

I. Group Leader Interview Protocol.....	211
J. Attachment Based Parenting Group Manual	212

LIST OF TABLES

Table # 1 Family Constellation.....	56
Table # 2 Ethnic Background	57
Table #3 Parent Demographics.....	57
Table #4 Relationship with Their Own Caregivers	60
Table #5 Data Analysis and Interpretation Steps.....	61
Table #6 Timeline for Communication of Needs Assessment Results.....	62
Table #7 Parents' Mental Health.....	63
Table #8 Reunification Process.....	63
Table #9 Discipline	64
Table #10 Appropriate Structure.....	64
Table #11 Advocating for educational needs	65
Table #12 Emotional Connection.....	65
Table #13 Separation.....	66
Table #14 Active Involvement in Childcare.....	66
Table #15 Engagement in play	67
Table #16 Estimated Time Commitment.....	78
Table #17 Component I: Personnel.....	88
Table #18 Component II: Personnel.....	91
Table #19 Component III: Personnel	95
Table #20 Program Budget	97
Table #21 Overview of Methods, Instruments, and Procedures- Evaluation Protocol I.....	99

Table #22 Overview of Methods, Instruments, and Procedures – Evaluation Protocol II.....	101
Table #23 Overview of Methods, Instruments and Procedures- Evaluation Protocol III	104
Table #24 Outline of Parenting Group Sessions	109
Table #25 Do’s and Don’ts of Special Play Time.....	129
Table #26 Program Evaluation Needs- Current and Desired State of Affairs.....	140
Table #27 Program Evaluation Protocol 1- Review of Methods, Instruments, and Procedures.....	149
Table #28 Eligibility Checklist	150
Table #29 Evaluation Question 1-Personnel, Responsibilities and Timelines	151
Table #30 Evaluation Protocol I- Summary of Results for Eligibility Criteria	152
Table #31 Program Evaluation Protocol II- Review of Methods, Instruments, and Procedures.....	154
Table #32 Evaluation Question 2- Personnel, Responsibilities and Timelines	155
Table #33 Program Implementation Checklist: Program Activities	157
Table #34 Program Implementation Checklist: Overview	158
Table #35 Adherence to Policy and Procedures	159
Table #36 Program Evaluation Protocol III- Review of Methods, Instruments and Procedures.....	161
Table #37 Evaluation Question 3- Personnel, Responsibilities and Timelines	162
Table #38 SMART Goal 1.....	164
Table #39 SMART Goal 2.....	165

Table #40 SMART Goal 3-Initial Parent Survey Questions and Responses.....	167
Table #41 SMART Goal 3- Relevant Questions and Responses from Group Leader Interview.....	168
Table #42 SMART Goal 3- Relevant Questions and Responses from Follow Up Parent Survey	169
Table #43 SMART Goal 4- Relevant Questions and Responses from Follow Up Parent Questionnaire.....	170
Table #44 SMART Goal 4- Relevant Questions and Responses from Group Leader Interview.....	171
Table #45 SMART Goal 7- Relevant Questions and Responses from Initial Parent Survey.....	173
Table #46 SMART Goal 7- Relevant Questions and Responses from Follow Up Parent Survey	173
Table #47 SMART Goal 7- Relevant Questions and Responses from Group Interview.....	174

LIST OF FIGURES

Figure #1 Sequencing of Activities for Component I	89
Figure #2 Sequencing of Activities for Component II	92
Figure #3 Sequencing of Activities for Component III.....	96

CHAPTER I

INTRODUCTION AND OVERVIEW

Abstract

This dissertation focuses on the design, implementation and evaluation of a psychoeducational program for single parents who have had a history of mental illness and that have been separated from their children. The program utilizes the program planning and evaluation framework presented by Maher (2000). This chapter describes the aim of the dissertation, the relevance of the dissertation topic, an overview of the program planning and evaluation phases, and a description of the dissertation process.

Introduction

The purpose of this dissertation was to document the process of designing, implementing, and evaluating a program to address the psychological needs of the families that reside at a supportive housing complex. In particular, the dissertation involved the design and implementation of a parenting program, entitled The Attachment Based Parenting Program. The program's primary aims were to provide parents with a history of mental illness an opportunity to explore their own attachment histories as well as to provide psychoeducation and skill building in the areas of discipline and attachment within a certain context. This program was conducted at a residential facility that provides housing and other services to mentally ill single parents who have recently been reunified with their children.

Relevance of Dissertation Project

There is considerable evidence to suggest that the quality of parent child attachment has an effect on a child's development and future relationships (Kobak, Cassidy, Lyons-Ruth & Ziv, 2006). Moreover, insecure attachment patterns occurring in the context of additional risk factors heighten the risk for the development of psychopathology in children (Kobak, et al., 2006). Residents of the supportive housing complex are known to have a history of mental illness and homelessness and have experienced prolonged separations from their children often due to their involvement with child protective services. Thus, the families at the residence face multiple barriers to secure attachment between parents and children. The prolonged separation likely disrupted the bond between parent and child, which was potentially already fragile due to the parents' ongoing struggles with mental illness (and in some cases substance abuse). In addition, there is considerable research to suggest that negative parent-child interaction patterns are also related to a parent's own childhood attachment experiences (Cordero, 2004).

The family reunification process is often difficult and results in a range of feelings in both parents and children. Often there is some ambivalence prior to the return of the children as parents question their readiness to resume the role of primary caregiver and children struggle with conflicting loyalties to their biological families and foster families (kinship or otherwise) (Cordero, 2004). In addition, the attachment bond has been disrupted due to the preceding abuse and/or neglect as well as due to the separation. All of these factors taken together suggest that families undergoing the reunification process are quite fragile and require additional supports to facilitate a smoother transition. In this

regard, recent findings suggest that children who reunify with their biological families after foster placement exhibit more negative outcomes than children who remain in the foster system (Gauthier, Fortin, & Jéliu, 2004). Frequently, when children return to their biological families, they exhibit severe behavior problems (Gauthier et al, 2004). Thus there appears to be a need for continual support and services for families undergoing the reunification process. Particularly as parents not only have to readjust to the role of parent, but also have to learn how to cope with the severe behavior problems that can develop in their children.

This dissertation will add to current knowledge by focusing on the attachment needs of a very specific population (parents with a mental illness recently reunified with their children). All parents in the program have a documented mental illness and meet criteria for the classification of Severely and Persistently Mentally Ill. The most common diagnoses of the parents are Schizophrenia, Bipolar Disorder and Major Depression; in addition, at least 6 of the parents have a history of substance abuse.

Serious mental illness can have a major impact on an individual's overall functioning and ability to parent; however, there is much evidence to indicate that given sufficient resources some individuals diagnosed with a serious mental illness can successfully parent their children (Risley-Curtiss; Stromwall, Hunt & Teska, 2004). Thus, it is important to provide those parents diagnosed with a serious mental illness with support to foster successful parenting (Risley-Curtiss et al, 2004). There is some evidence to suggest that mental health assessment and treatment of adults with mental illness typically focuses on addressing and managing symptoms with little focus on their roles as parents (Risley-Curtiss et al., 2004). Thus the program designed and implemented for the

population of parents at this supportive housing residence provides an excellent opportunity to supplement the ongoing mental health treatment received by many of the parents who reside there. The program was structured to provide an opportunity for parents to explore their past histories as well as begin to build the skills related to attachment and appropriate parenting practices.

Overview of Program Design, Implementation and Evaluation Framework

The program design, implementation and evaluation process of this dissertation utilized the framework presented in Maher's (2000) *Resource Guide for Planning and Evaluating Human Service Programs*. There are four phases to this model: The Clarification Phase, Design Phase, Implementation Phase and Evaluation Phase. The Clarification Phase provides an opportunity to further delineate relevant characteristics of the client and target population. Additionally within this phase there are multiple areas assessed, namely the needs of the target population and the context within which the client and target population function. The findings from this assessment are used to generate a program design. The program design is clearly delineated and all aspects of the program are considered, including goals, components, staff participation, budgetary issues and so forth. Following this, the program is implemented and there are procedures put in place to monitor whether the program is implemented properly and any adjustments are made along the way if deemed necessary. Finally, the program is evaluated to determine whether the program has added any value to the target population (Maher, 2000).

Description of the Dissertation Process

Through preliminary discussions with the administrators at the residence as well as the program design and evaluation staff at their parent organization, it was determined that there would likely be value in the formulation of a new program to address the attachment needs that are noticeable among the parents and their children that live at the residence. The attachment needs of families at the residence have been an ongoing concern for staff of this program, but they have been unable to address these concerns due to a lack of resources. The Senior Administrator of the program, recognized that many of the parents who live at the residence have issues in the area of attachment due to the separation from their children. She has noticed over the years a number of parent-child relationships that were strained and problematic due to the child's placement in foster care and has for some time considered starting a program to begin to address these concerns. Of particular concern to the client and other staff members were parents' abilities to be appropriately responsive to the needs of their children. However, at the outset of this process, the problem was not clearly defined, thus a needs assessment was conducted to further elucidate the nature of the problem.

The needs assessment utilized the framework presented in Maher's (2000) *Resource Guide for Planning and Evaluating Human Service Programs*, which defines a need as "as the discrepancy between a current state of affairs having to do with psychological or educational functioning of the target population and a desired state of affairs pertinent to it" (p. 14). The process of determining the needs of the target population involved obtaining, analyzing and interpreting data about their needs and using this data to assess the nature and scope of needs (Maher, 2000). In order to assess the needs of the target population at

the residence, a staff interview was conducted. The interview focused on a number of areas, not all of which could be addressed by the program design. The three main domains that were assessed through this process were the psychological concerns of the parents, parenting skills, and attachment, which were chosen as it was assumed that each had a possible impact on the parent-child relationship. The findings of this needs assessment resulted in further data based clarification of the needs of the target population, defined for the purposes of this project as the parents who reside at the residence. After careful consideration and review of the findings from the assessment, it was determined that the program would involve a parenting group designed to begin to address the attachment based needs of these parents. There were particular needs chosen from the needs assessment that became the focus of the parenting group which include: parents' need to process their own parenting history and how it impacts their current relationship with their children, parents' need to process the separation from their child(ren) and its effect on the parent-child relationship, parents' need for psychoeducation regarding appropriate discipline practices, and parents' need for psychoeducation about the nature of attachment as well as the need to learn specific skills to begin improving attachment between themselves and their children. In addition, during the needs assessment process various staff members were consulted regarding their opinions about methods of engaging residents in the program.

Following this, an assessment of contextual factors related to program implementation was completed. The methods used to carry out the assessment included interviews with key stakeholders and participant observation. The interviews were conducted with the former director of the residence and the client. A thorough

investigation of the context illustrated that there were some possible obstacles to the program design, implementation and evaluation process. These included resistance from some stakeholders to actively participate in the planning process and limited financial resources of the agency.

Upon completion of the needs and context assessment, it was determined that the parenting group would meet once a week for 12 weeks and would run from September 2008- December 2008. In addition, research was conducted to determine material to utilize in the group. Given the findings of the needs assessment, group topics were generated and research was conducted to identify an appropriate framework for each session. An overarching theme of the group was attachment and the many ways it can be fostered and hampered. It was determined that the group would be a combination of process and psychoeducation allowing group members to discuss feelings about their own histories and the impact of separation from their children, followed by specific activities designed to help them begin the process of improving their relationship with their children. It was also determined that the group would be co-facilitated by the consultant and a staff member, to help engage participants as well as to ensure that the program could be replicated once the consultant left the organization.

The data gathered from the needs and context assessments were used to inform the program design. There were three phases or components to the program design which were: orientation of staff to the program, recruitment of parents to participate in the program, and the parenting group. During the initial phase, the consultant met with program staff to present the group and discuss possible participants. Once individuals were identified for group participation, they were contacted and attended an orientation meeting

to explain the nature/purpose of the group. The consultant/group leader presented the group and asked interested parents about any concerns they had about parenting groups and what topics they wished to cover. The final component or phase of the program was the Psychoeducational parenting group which ran for 12 weeks throughout the fall of 2008.

A thorough evaluation of the program is outside of the scope of this dissertation project; however, an evaluation plan was formulated. Three questions were considered in order to assess whether the program added value to the target population. These questions were: Who participated in the program? How was the program implemented with respect to participants? What appears to be the benefit of the program to participants?

The evaluation plan utilized a number of measures to assess the effectiveness of the program. Each interview and or questionnaire was designed by the consultant as there was no validated instrument that was readily available that would suit the needs of this evaluation process. In addition, each measure designed is customized to assess this program design and the outcomes for this specific target population.

This dissertation will provide a description of this uncommon residential facility as well as a thorough review of the program design process at such a facility. The end result will also include a discussion of the process and any challenges faced while completing it. Furthermore, the dissertation will include a review of the literature, a description of the process used in working with the organization, a description of the target population, its needs and the contexts surrounding the project. The dissertation will also include the program design and the evaluation plan as well as conclusions and recommendations about the program.

Summary

This dissertation utilized the program planning and evaluation framework outlined in Maher (2000) to design a program to address the psychological needs of parents with a history of mental illness who reside at a supportive housing complex. Parents who reside at this complex have been separated from their children and are undergoing the reunification process. The separation and subsequent reunification can negatively impact the attachment relationship between parent and child. Staff at the residence recognized that parents could use additional support to address the attachment disruptions many have experienced with their children. The parenting program designed and implemented, ran for 12 weeks and allowed parents an opportunity to not only process their own attachment histories but also to learn skills to begin to improve their relationships with their children.

CHAPTER II

REVIEW OF LITERATURE

Abstract

The following literature review will explore and highlight attachment theory, attachment interventions such as play therapy and group treatment methods, the effects of foster care on child development and issues regarding family reunification. The theories, practices and issues addressed in this chapter all influenced the program design and implementation of this dissertation project.

INTRODUCTION

Parent-child attachment has a significant impact on a child's later development (Cassidy, Lyons-Ruth & Ziv, 2006). There are a number of factors that can negatively affect the attachment relationship between parent and child including parental mental illness, abuse and neglect, separation, and even a parent's own history of trauma (Kobak et al, 2006; Howe & Fearnley, 2003; Grienemberger, Kelly & Slade, 2005). Given the long term impact of the attachment relationship, several theorists and researchers have explored ways in which to foster and improve attachment. The following literature review will explore both the nature of attachment, as well as factors that negatively impact it and methods to improve and foster attachment.

Parents with Mental Illness

Mental illness in parents can have a considerable and long lasting impact on the development of their children (Seifer, 2003). For children with mentally ill parents, rates of mental illness have been found to be higher throughout the child's lifespan, and are often linked to difficulties in school and problems in general social adjustment (Seifer, 2003). Differences in the lives of children whose parents suffer from mental illness can be noticeable in the first weeks of life and are most obvious in the social-emotional domain of functioning (Seifer, 2003). Not only do children of mentally ill parents face risks for poor social and emotional functioning, but they also may have to manage unrealistic expectations placed on them by their parents (Ackerson, 2003). It is not uncommon for children of mentally ill parents to experience "role reversals" wherein the children assume adult responsibilities due to their parents' incapacitation (Ackerson, 2003). As a result boundary issues may exist between parent and child, thus exacerbating a parent's difficulty in appropriately disciplining their children (Ackerson, 2003). In addition, disrupted attachment bonds are found in infants of mentally ill parents that can lead to disorganized or insecure attachment (Seifer, 2003).

Research indicates that parenting sensitivity (i.e. appropriate responsiveness to the child's signals) is a significant mechanism for promoting secure attachment in infants (Seifer, 2003). The ability of parents to be sensitive is often impaired when parents struggle with their own mental illness (Seifer, 2003). In fact, maternal depression has been found to be associated with lower maternal sensitivity, which in turn is correlated with insecure infant attachment (Seifer, 2003; Mercer, 2006). The absence of other social-contextual risks (e.g. poverty, homelessness, parental substance abuse) protects

children from the individual risk of parental illness (Seifer, 2003). Unfortunately, for the children who reside at the facility there are numerous social-contextual risks that compound the effects of their parents' mental illness.

Research has shown that risk patterns for children vary depending on the type of parental mental illness (Ahern, 2003). For instance, children of depressed parents have a 13-fold increase in risk for major childhood depressive disorder when compared to children of parents who are not depressed (Ahern, 2003). These depressive disorders in offspring were found to recur and result in continual impairment in social and other role functioning (Hammen, 2003). In addition, male children of depressed parents are more at risk for developing childhood conduct disorder (Ahern, 2003). Certain research suggests that there is evidence of "relative deficits" in cognitive performance in infants and toddlers of depressed mothers (Hammen, 2003).

As stated previously, chronic stressors exacerbate the effects of parental mental illness. In fact, chronic stress in the family was found in some studies of maternal depression to be a unique predictor of children's adjustment and symptoms, over and above the effects of the mother's symptoms and history of mood disorder. It has also been suggested that depressed adults and their children tend to create stressful life events in the sense that they experience elevated rates of stressors that they have at least partially contributed to (Hammen, 2003).

Children whose parents are bipolar are 2.6 times more likely to develop a mental disorder of any sort and 4 times more likely to develop an affective disorder. As with any mentally ill parent, parental sensitivity to the child's needs is severely limited. In addition, due to the cyclical nature of bipolar disorder, children often experience a

disruption in the continuity of their care when parents have a manic episode. Children need consistency in their lives to develop appropriately and can find the erratic behavior exhibited by their parents during a manic episode as frightening (Ahern, 2003).

Children of substance abusers exhibit a different constellation of symptoms. They are more likely to exhibit externalizing problems such as delinquency, truancy, and other school-related problems. They also have an increased risk for developing ADHD, oppositional defiant disorder, or conduct disorder (Ahern, 2003).

Those children whose parents suffer from psychotic disorders are vulnerable to developmental delays, particularly in the areas of language and communication skills (Ahern, 2003). These children are also at risk for emotional problems due to parental coercion, isolation and physical danger as a result of their parents' poor reality testing (Ahern, 2003). Children also have an increased risk of becoming seriously mentally ill in the long-term; this chance increases considerably if both parents have psychotic disorders (Ahern, 2003). Parental psychosis can also negatively impact attachment (Hipwell, Goosens, Mehuish, & Kumar, 2000). While the mechanism for this finding is unknown, there is some evidence to suggest that the interactions between infants and mothers with a history of psychosis tend "to be more frequently tense and disorganized, with less shared affect and mutual enjoyment and fewer reciprocal behaviors" (Hipwell, et al., 2000, p. 159).

There are some parents with severe mental illness who present a potential risk to their children and it is these parents who are often the focus of the child welfare system. This seems to be of particular concern for parents who are in the midst of a manic or

psychotic episode. In these instances, often professional intervention and family support are needed when available (Ackerson, 2003).

A qualitative study conducted with parents who have a history of serious persistent mental illness provided an in depth exploration of their experiences (Ackerson, 2003). A number of themes emerged from this study including concerns about stigma associated with their mental illness and how it impacts their children (Ackerson, 2003). The authors found that many participants recognized that their parenting ability was significantly impaired during acute psychiatric episodes (Ackerson, 2003). These parents were able to recognize that their mental illness affected their ability to discipline their children properly (Ackerson, 2003). Some noted that they were more permissive with their children due to guilt associated with being a mentally ill parent (Ackerson, 2003). Other's attested to the fact that they engaged in harsh discipline with their children during acute episodes "sometimes when I was sick I would go overboard with the spankings... so as far as discipline goes, I used to discipline them when I was sick, and it was wrong. So now I don't punish when I'm sick... I shy away because I've done it in the wrong way before" (Ackerson, 2003, p. 114).

Attachment

Attachment behavior has been defined by Bowlby as "any form of behavior that results in a person attaining or retaining proximity to some other differentiated and preferred individual, usually conceived as stronger and/or wiser" (Quoted in, Feeney, Noller & Roberts, 2000, p. 185). Bowlby's attachment theory is largely an evolutionary one as infants are believed to have a biological drive to seek proximity to a protective adult to survive (Schoffield & Beck, 2005). Attachment is one of several proximity

seeking systems, which also include affiliation, sexuality and care-giving (Howe, 2006). The defining feature of an attachment bond includes proximity seeking (including separation protest), secure base and safe haven (Feeney, Noller & Roberts, 2000). The attachment system is used to provide protection at times of danger and attachment related behaviors are triggered whenever an infant experiences anxiety, fear, confusion and feelings of abandonment (Howe, 2006).

Typically in this system, the primary caregiver acts as the attachment figure that is used as a secure base or safe haven. The infant's level of confidence in the secure base provided by the caregiver determines the extent to which they feel free to explore, play and learn (Schoffield & Beek, 2005). When children utilize their "secure base" they are often in an emotionally dysregulated state (Howe, 2006). An appropriately sensitive caregiver has the capacity to provide a stabilizing influence on the child and can often help the child regulate and manage arousal and distress (Howe, 2006). The caregiver is able to do this by recognizing, understanding and appropriately responding to the child's internal mental state (Howe & Fearnley, 2003). This process has been called co-regulation (Howe & Fearnley, 2003). It is this consistent experience of co-regulation that results in a child who is able to "flexibly regulate their own emotional states through interaction with others, which in turn forms the basis of good theory of mind, sound mentalizing capacities, resilience, social competence and high reflective function" (Howe & Fearnley, 2003, p. 376).

Mentalizing, an important aspect of psychological functioning, is the ability to understand oneself and others as psychological beings, namely "how feelings affect behavior and behavior affects other people" (Howe & Fearnley, 2003, p. 379). A

caregiver's ability to provide a secure base, to observe the child's mind and help the child regulate affect, form the basis for secure attachment (Howe, 2006). Secure attachment provides a host of benefits to a child, as children who are securely attached are more likely to experience healthy psychosocial development, improved social cognition, higher levels of self esteem, and a sense of self-efficacy (Howe, 2006).

A child who has achieved a secure attachment will respond with considerable distress when separated for more than a day or two from the attachment figure. This response can occur at a young age. The response of a young child to the loss of an attachment figure can be parallel to the grief response of a bereaved adult. In such cases where separation occurs, playing, learning and other developmental processes may be stunted or placed on hold for a period of months. A child's physical health can also be impacted by this grief process. When a separation lasts for longer periods of time or there is no hope of reunion, a child's distress can be considerable. However, if an emotionally supportive caregiver is present in the child's life, it can mitigate the response and allow the child to recover from the previous loss and form a new attachment. This process may take a significant amount of time and over the course of recovery, the child could exhibit depression, crying, eating and sleep disturbances, failure to play and often regression from recently achieved developmental milestones (e.g. toilet training) (Mercer, 2006).

The attachment system is activated by threat or loss, separation or rejection. When this occurs, various defenses are used to stay connected. The type of defense used is typically dependent on the individual's attachment style. Thus a securely attached individual uses the simpler, more direct route to feeling safe while the avoidant individual

represses his or her feelings to avoid feeling unsafe in relationships. Conversely, a person who is ambivalently attached may become highly sensitive and vigilant within the attachment relationship while one with disorganized or unresolved attachment is more likely to become overwhelmed by the stress to the point that they lose control of their actions (Van Eecke, Chope, & Emmelkamp, 2006).

Avoidant and ambivalent attachment in children typically occurs in the context of unresponsive or inconsistent care giving (Howe, 2006). This type of caregiving is often found in neglectful environments (Howe & Fearnely, 2003). Children in this context must organize their attachment behavior (e.g. proximity seeking) in a manner that will increase the availability of their caregiver at times of need and distress (Howe, 2006). This involves strategies such as downplaying or excluding certain types of psychological information from conscious processing, which inevitably affects the child's ability to cope in a well rounded and reflective way with normal stresses that occur in social relationships (Howe, 2006).

Children with avoidant attachment have caregivers who become anxious and rejecting whenever others place emotional demands on them. In order to cope with this, the children exclude attachment based feelings and behaviors from conscious processing. As a result they become emotionally self-contained and do not seek comfort from others, which allows them to be accepted by their caregivers. This pattern is particularly noticeable in physically and emotionally abused children who often do not seek comfort or safety when upset, ill, vulnerable or frightened because they have learned that they are not likely to receive the comfort they need. In fact, attachment related behaviors (e.g. seeking comfort) often makes matters worse as it may lead to more dangerous behavior

from their caregiver. The long term affects of this are far reaching, as these children become anxious at displays of need, weakness, dependency and vulnerability in others; thus, any relationship where there are attachment related issues can result in feelings of anxiety, distress and aggression (Howe, 2006).

Children with an ambivalent attachment style (resistant or dependant) have caregivers who are inconsistent and unable to recognize other people's needs and attachment signals. To cope with caregivers who have these limitations, children will maximize their distress and attachment behavior in order to increase their chances of getting noticed. Children with this attachment style are often demanding and rarely satisfied or reassured (Howe, 2006).

The children that find it most difficult to organize an attachment strategy are those whose caregivers are the direct cause of their distress and fear (Howe, 2006). Caregivers, who frighten, threaten, physically and sexually abuse or neglect their children typically produce children with disorganized attachment (Howe, 2006; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2005). These children struggle to organize an attachment strategy that will increase their caregivers availability and thus become disorganized (Howe, 2006). As they grow older, children with disorganized attachment cope with their environment by taking care of their own safety and needs (Howe, 2006). As a result, these children often utilize a variety of controlling strategies such as "compulsive compliance, compulsive care- giving, compulsive self reliance and coercion" (Howe, 2006, p.129). In addition, these early relational traumas, such as neglect, abuse, separation and loss are sources of prolonged and intense negative arousal, which some

believe may impact the affective regulatory systems in the brain (e.g. the autonomic nervous system) (Oosterman & Schuengel, 2007).

The co-regulation process is often hampered or non-existent in situations of abuse and neglect. In such situations, children are often not helped to regulate their minds when highly aroused, which can have far-reaching adverse consequences for development and reduce the child's capacity for empathy. Children who exhibit disorganized attachment behavior in infancy are at the greatest risk for developing behavior and mental health problems. Several studies have shown that disorganized attachment in infancy is predictive of problematic stress management, externalizing behavior problems and dissociated behavior in adolescence (Howe & Fearnley, 2003).

Intergenerational Transmission of Attachment Styles

A number of studies have consistently found a high correlation between mother and infant's attachment style as assessed by the Adult Attachment Interview and the strange situation respectively (Besser & Piel, 2005). This finding has been replicated in studies where the data were examined prospectively, retrospectively or concurrently (Besser & Piel, 2005). In general, mother's categorized as secure are significantly more likely to have children who are securely attached (Mercer, 2006).

Further studies have been conducted to assess the possible mechanisms responsible for the transmission of attachment styles between parent and infant (Besser & Piel, 2005). Some studies have indicated that a mother's ability to be responsive, sensitive and provide support as well as the quality of parent-child interactions are the mechanism by which this transmission occurs (Besser & Piel, 2005). Maternal sensitivity is typically defined as "cooperation, acceptance and contingent responsiveness and

pleasurable affect” (Grienberger, et al, 2005, p.300). In a meta-analysis that examined the relationship between adult attachment (as measured by the Adult Attachment Interview) parental sensitivity and infant attachment, modest to moderate links were found between autonomous (i.e. secure) adult attachment, maternal sensitivity to infant attachment signals and infant attachment style (Grienberger et al., 2005). In fact this analysis found that maternal attachment style only explained 12% of the variance in parental sensitivity while parental sensitivity accounted for only 10% of the variance in infant attachment (Grienberger et al., 2005). This indicates that other factors are also important in the intergenerational transmission of attachment style (Grienberger et al., 2005). Thus it is posited that maternal mentalization abilities account for an additional portion of the variance (Grienberger, et al, 2005).

A parent’s ability to mentalize is vital to his or her ability to manage and regulate affect. Painful or negative affect (in either the caregiver or child) is able to become manageable only because the caregiver is able to see the negative affect or disturbing thoughts as mere mental states rather than concrete reality, which allows for modulation and change of affect and/or thoughts over time. This ability then allows the caregiver to remain emotionally engaged with the child and in control enough to contain the infant’s distress. The containment of this distress makes it more tolerable for the child and allows the child to develop a sense of mastery. As the child matures and engages in many more of these regulatory interactions with his or her parent, the child is eventually able to self-regulate. A caregiver’s ability to regulate the infant’s distress is considered to be vital to the child’s ultimate feeling of security and secure attachment (Grienberger, et al., 2005).

Attachment-Based Programs

There are several programs and interventions designed to address issues around attachment. A review of such programs and important theoretical considerations are discussed as aspects of these interventions were incorporated into the program design. One such program is the Circle of Security project. The key ingredients for change in this program are the relationship between the therapist and the parent, affect regulation and reflective functioning (Powell, Cooper, Hoffman & Marvin, 2007). The authors posit that children will learn to manage their affect through their parents; thus, the intervention works to help parents learn to manage their affect, particularly when strong feelings arise around their own history of emotional deprivation (Powell et al., 2007). A major goal of the group is to provide a safe space that acts as a holding environment for these strong emotions that have chronically interfered with their ability to respond to their child's needs. The intervention is also meant to increase parents' capacity for self-reflection. Fonagy et al (1994) found that adults with high reflective functioning were able to rise above a deprived background and promote attachment security in their children. Reflective functioning has been defined as "the psychological capacity for understanding one's own mental states, thoughts, feelings and intentions as well as those for the other" (Powell, Cooper, Hoffman & Marvin, 2007, p.177). Thus attempts to improve this capacity among participants are built into the program. Parents are encouraged to engage in a reflective dialogue with the therapist and other members of the group (Powell et al., 2007).

The Circle of Security Project attempts to take into account parents' own attachment issues and history of emotional deprivation and how these may affect the

attachment bond between them and their children. Issues highlighted in this program are similar to those faced by parents who participated in this dissertation project. Namely, struggles with their own insecure attachment. Parents who have participated in the Circle of Security Project have noted that taking steps to improve their relationship with their children evoked both positive and negative feelings as they experienced joy in a closer relationship with their children while simultaneously experiencing pain as they begin to “give their child that which was not given to them in their own early years” (Powell et al, 2007, p. 175). At the heart of the intervention is the idea that children with insecure attachments have learned to divert their caregivers away from their basic attachment needs, because seeking a connection with their caregivers evokes distress in their parents (Powell et al., 2007).

Through their research, the authors speculate that there are core sensitivities that are thought to be an integral part of personality structure and operate as “perceived but unspoken rules and requirements” that an individual believes must be followed in order to avoid experiencing abandonment (Powell et al, 2007, p. 177). They suggest that there are three basic patterns that form a continuum from flexible and adaptive defensive strategies to rigid and pervasive personality styles. The first basic pattern can be found in the “separation-sensitive parents” who believe that in order to avoid abandonment they must focus on the needs of others while ignoring their own wants, needs and feelings. Implicit in this strategy is the belief that if they act on their own needs they will be abandoned by those closest to them. The second pattern is found in the “esteem-sensitive parent”, who believes that they are unworthy and unlovable. In order to protect themselves from abandonment they must prove that they are special through performing,

achieving and being acknowledged by others. The final pattern is the “safety-sensitive parent” who has learned throughout their life that in order to be in a relationship one must give up having a self and be controlled by the other. Thus, the only way to have an intact sense of self is to be isolated and closed off from others (Powell et al., 2007). While these patterns are largely theoretical, preliminary interviews with key staff members at the residence indicate that these patterns may be present to some extent among many of the parents who participated in this dissertation.

While the Circle of Security project was designed specifically to foster attachment between parents and children, other groups with a slightly different focus have also been found to improve attachment relationships. For instance, The Compassion Workshop is a structured group treatment developed for spouse, child and elder abusers that has been developed over 10 years of work with more than 5,000 abusers (Greif & Ephross, 2005; Stosny, 1995). The group is meant to target what the developer describes as “attachment abuse”, which is defined as “that which impairs, subverts, distorts, or damages the self-building nature of attachment interaction” (Stosny, 1995, p.4). The group employs a didactic and process oriented format to help group members explore their own history of abuse and ways in which they can learn to have compassion for themselves as well as their victims (Stosny, 1995). The primary goals of the group are to address deficits in perspective taking, increase sympathy for the self and attachment figures, to learn to validate the emotional experience of loved ones and to increase emotional vocabulary (Stosny, 1995).

The treatment provided by the Compassion Workshop is based on the assumption that individuals attempt to control others when they feel powerless themselves and that

abuse is an external method to regulate affect (Greif & Ephross, 2005; Stosny, 1995). Thus, the Compassion Workshop strives to eliminate the need to exert power over others by fostering empowerment amongst participants and allowing them the opportunity to feel that they have power over their own internal experience (Greif & Ephross, 2005). The mechanism for this process is the development of self-regulation skills that lead to “moral agency” (Greif & Ephross, 2005, p. 232). In order to learn these self-regulation skills, the participants must learn compassion for themselves and others (Stosny, 1995). To begin to help participants learn compassion for others, many of the activities in the group are designed to teach perspective taking, so that they are able to better understand the impact of their behavior on others (Stosny, 1995). The belief is that the ability to take another’s perspective will increase participants’ compassion for others and decrease aggressive and abusive behavior (Stosny, 1995).

The compassion workshop is made up of structured modules, many of which are designed to teach participants how to identify and label the feelings of anger arousal (e.g. physiological signs) as well as triggers for anger (Greif & Ephross, 2005). The modules help participants understand that triggers can be more than just situational (e.g. a disobedient child) and are often internal (Stosny, 1995). Internal triggers for abusive acting out can include guilt, shame, abandonment, and anxiety (Greif & Ephross, 2005). The assumption is that by helping participants establish insight into the causes of their anger, they can begin to increase compassion for themselves by understanding that much of their anger is related to their unmet emotional needs (Stosny, 1995). This then allows them to identify more appropriate ways to communicate their feelings and meet their emotional needs (Stosny, 1995).

The centerpiece of the skill building in the Compassion Workshop is the multi-step emotion regulation technique HEALS. This process involves identifying and explaining the underlying hurt provoked by a situation (e.g. feeling unimportant, disregarded, accused, guilty, mistrusted, devalued, rejected, powerless, unloveable). The next step is to apply self-compassion to heal the hurt identified, and to then love yourself by feeling compassion for loved ones. Finally, participants learn to solve the problem that initially provoked the hurt feelings. This allows participants to learn how to appropriately resolve a conflict by understanding that the goal is not to “win the dispute” but to have everyone involved feel understood, important and lovable. The participants are encouraged to use these skills in role play during session and at home with their families (Greif & Ephross, 2005).

Child Maltreatment

Every year millions of children are referred to child protective service agencies. The U.S. Department of Health and Human Services reported that in the year 2000 there were 3 million referrals to child protective service agencies for approximately 5 million children. This same report indicated that in 2000 approximately 879,000 children were victims of abuse or neglect with almost two-thirds of these children suffering neglect, while 19% were physically abused, 10% were sexually abused and 8% were emotionally abused. Many of these children are removed from the home as a result of their abuse and/or neglect. Infants and children under the age of 6 comprise the largest age group of foster children (McWey & Mullis, 2004).

There seems to be a link between the type of maltreatment experienced by the child and the behavioral picture they present (McWey, 2004). For instance, aggression,

delinquency, suicide, cognitive and academic impairment are often correlated with child physical abuse (McWey, 2004). Children who have experienced emotional abuse often exhibit internalizing and externalizing behaviors, social impairments and low self-esteem (McWey, 2004). There is some research to suggest the type of maltreatment also impacts a child's attachment style in that children who experience neglect are anxiously attached while children who were physically abused are avoidantly attached (McWey, 2004). Abuse is not always the result of malicious intent; however, if abuse occurs frequently, the ensuing emotional response from the child of fear, mistrust or abandonment may be the same whether the abuse was intentional or not (Webb & Leehan, 1996).

It is not entirely clear what mechanisms underlie the correlation between physical abuse and neglect in childhood and poor social and emotional development. There are likely numerous factors that explain this connection. For instance, research indicates that child abuse and severe neglect can affect brain anatomy and physiology, which may explain, to some extent, findings that child abuse can result in lifelong vulnerability to depression and personality disorders (Haight., Kagle, Black, 2003). Additionally, negative social and emotional consequences of abuse result, in part, from the fact that abused children often live in constant fear for their safety (Webb & Leehan, 1996). Thus, they are not able to devote attention and energy to the "higher goals of love, belonging and self-esteem", which results in the undermining of personality development (Webb & Leehan, 1996, p. 4).

The age of the child abused can determine the effects on the child's development. The level of support available to the abused child often influences the range, intensity and longevity of the effects of the abuse. Physical abuse can have long lasting effects on

development, as it can impair a child's ability to establish a basic trust in oneself and others, which can ultimately impact future intimate relationships. In addition, physical abuse impacts one's self-esteem and can lead to feelings of anger, guilt and depression that are often debilitating and difficult to resolve (Webb & Leehan, 1996).

Foster Care

There are several factors that contribute to a child's placement in foster care. For instance, child abuse, neglect or maltreatment in some form is often linked to removal from the home (Hoffman & Rosenheck, 2001). Homelessness, severe parental mental illness and/or substance abuse can also yield the same result (Ackerson, 2003; Hoffman & Rosenheck, 2001). Parents who struggle with severe mental illness often fear losing custody of their children, particularly during moments of acute psychiatric crisis (Ackerson, 2003). In a qualitative study conducted with Severely and Persistently Mentally Ill parents', loss of custody or stress related to custody issues was a common theme among participants (Ackerson, 2003). Said participants often noted that they were at risk for losing custody of their children during hospitalizations, particularly if there was limited social support to aid them in times of crisis (Ackerson, 2003). Many of the parents who did experience either temporary or permanent loss of custody via the child welfare system, felt that their psychiatric diagnoses were often used against them by case workers, leaving the parents feeling marginalized and stigmatized (Ackerson, 2003).

Mental illness and substance abuse are also two common risk factors for homelessness. For the past two decades or so, there has been a dramatic increase in homelessness among women and children. As of 2001, women comprised over one-fifth of the adult homeless population. During the same time period, it was found that families

headed primarily by single mothers of young children made up at least one-third of the total homeless population. Approximately 70% of homeless mothers are separated from at least one of their minor children, making family preservation a major concern for this population. Oftentimes, homeless mothers lose their children to involuntary foster placement if their homelessness is viewed as neglect by the child welfare system. Once their children are removed, these homeless women often lose welfare benefits and food stamps, which further decrease their ability to secure housing and reunify their families. Thus, homeless mothers may be unable to regain custody of their children even without a prior history of parental abuse or neglect (Hoffman & Rosenheck, 201).

The removal process can be particularly difficult for children as it results in a major disruption that is often never fully explained. Oftentimes foster children undergo a great deal of confusion while being taken from their homes. They are typically confused about the reasons for being placed in foster care and what will happen in the future (Whiting & Lee, 2003).

In recent years, increasing numbers of infants and young children are placed in foster care and remain for longer periods of time, which places their emerging attachment relationships with their biological parents at risk (Haight, et al., 2003). Despite the history of abuse and/or neglect and the resulting attachment difficulties, many foster children still feel an emotional pull towards their biological parents. Littner (1975) stated when discussing the plight of the foster child and the link to his or her biological parents “For better or worse, they are the roots to the past, his support and foundation. When he is separated from them, he feels that he has lost a part of himself” (quoted in McWey & Mullis, 2004, p. 293).

Placing children in foster care creates a dilemma for social workers and caseworkers as the process itself is often traumatic and can have long lasting impacts; however, the long-term psychological risks for children remaining in their abusive homes can outweigh the consequences of the separation from their biological families (Kenrick, 2000). Unfortunately, children may not see it this way. Whiting & Lee (2003) interviewed several foster children about their experiences; one child summed up the anguish that foster children experience when he stated

“Yeah, foster care is just sick! I don’t want to hear about it at all. You get taken away from your parents. It ruins your life! Your heart is totally destroyed, and the only thing that is left working in your body is your brain... That is why I want out of this foster care right now!” (p. 292)

Foster placement often results in numerous losses for the child. It hastens the loss of an attachment figure, which can present a real and considerable psychological challenge for the child; in addition to this loss, children also lose the possibility of a “normal” childhood (Schofield, 2002). Although their birth family may be dysfunctional it is at least a recognizable family like other people, “a ‘real’ family to whom one [is] biologically connected and which [is] therefore socially legitimate” (Schofield, 2002, p. 266). Thus, children who are placed in foster care may feel stigmatized and different from their peers due to their status as “foster children”. In addition, the loss of siblings can have a significant impact on the functioning of children in foster care (McWey, 2004). Some suggest that the sibling relationship is more intense when there is chaos and disruption in the home and those strong sibling relationships may serve as a protective factor for children raised in abusive homes (McWey, 2004). Thus, when children are placed in foster care and separated from a sibling, the disruption of the sibling bond may be experienced as a profound loss for the child (McWey, 2004). One particular study

found that losses were correlated with avoidant attachment as the more losses the child experienced the higher the level of avoidant attachment (McWey, 2004). In this sample of children, losses included the loss of parents, separation from siblings and repeated moves from one foster home to another (McWey, 2004).

In one study that identified a sample of children who received supervised visitation with their biological parents and were to be reunified with their families, a number of factors contributed to an avoidant attachment style, namely the age of the child at removal, the number of months in foster care and the child's birth order (McWey, 2004). Thus, the older the child was at removal, the longer he or she remained in foster care and the higher the birth order, the more likely the child was to be avoidantly attached (McWey, 2004). Other studies have found similar results, suggesting that infants and young children (under the age of 2), have a better chance of developing secure attachments to their foster parents than older children, particularly if the foster parent is classified as securely attached (or autonomous based on a classification from the Adult Attachment Interview) (Gauthier, et al., 2004). The older children are when removed from their biological family, the more likely they are to undergo a more severe protest-mourning reaction to the loss of their primary attachment figure (Gauthier, et al., 2004).

Children who enter foster care have suffered life stressors and maltreatment that often makes it difficult to trust others (Schoffield & Beck, 2005). Maltreated children have often developed problematic and insecure attachment strategies in response to harmful and dangerous situations (Schoffield & Beck, 2005). These insecure attachment strategies (i.e. avoidant, ambivalent, disorganized) are often not useful in establishing healthy relationships and eliciting or responding to sensitive care, but continue to be

employed in new caregiving situations with their foster parents (Schoffield & Beck, 2005; Howe, 2006). Thus the maltreated children will often avoid emotional contact with their new caregivers (i.e. foster parents) until the relationship feels safe (Howe, 2006). This is in line with Bowlby's assertion that children who lose an attachment figure will continue to exhibit distress even if the attachment figure is replaced by another capable caregiver (McWey, 2004). However, this presents a major challenge for foster parents seeking to establish positive relationships with the children placed in their care (Schoffield & Beck, 2005).

Family Reunification

Research has shown that risk factors for children and families of color to enter the child welfare system include substance abuse, domestic violence, parental stress, mental illness, parental incarceration and poverty. These factors may also affect reunification services once the child is placed in the system. National statistics indicate that children of color are disproportionately represented in the child welfare system and tend to remain in foster care for longer periods of time. In fact, a number of studies indicate that children of color, particularly African American children, reunify with their families less frequently than white children. Family structure has also been found to affect reunification as single parent families reunify at a slower pace than two parent families regardless of the gender of the parent (Hines, Lee, Osterling, Drabble, 2007).

In order to improve the instability children face in the foster care system, the Adoption and Safe Families Act of 1997 was passed, which requires a reduction in a child's length of stay in state custody (McWey & Mullis, 2004). The act specifies that families receive up to 15-18 months of family reunification services (Hines et al., 2007).

After this time period, families are either reunited or parental rights are terminated and the child receives post permanency planning services (Hines et al., 2007).

Typically when reunification is a goal, foster agencies require that the parent maintain consistent visitation with his or her child (McWey & Mullis, 2004). Research on children in foster care has found that the frequency of parental visitation is a stronger predictor of reunification than parental characteristics, child characteristics and the reason for child placement (Leathers, 2003). This is likely due to the fact that children who have more consistent and frequent contact with their biological parents are more securely attached and are better adjusted than children who have less contact with their families while in foster care (McWey & Mullis, 2004).

The reunification process can be confusing for all involved, but particularly for children. One child interviewed about the challenges of foster care and reunification notes, that the process can be particularly confusing for infants. He reports “it is also tough for a baby, because they grow up with foster parents, thinking they are his real parents, and once he goes back to his real parents; he is like ‘what the heck, who are they?’” (Whiting, & Lee, 2003, p. 292).

Reunification is also often a difficult process for parents as they struggle to re-establish parenting routines and roles. Over the course of the separation, children have continued to develop and grow and often present with new and difficult developmental challenges upon return to their biological parents. Reintegration into the home becomes increasingly difficult as parents are not yet equipped to deal with these new challenges. Additionally, children must adapt to new rules and expectations that may conflict with those set by previous caregivers (e.g. foster parents). This can result in behavioral

difficulties and emotional distress that further complicates the reunification process (Bellamy, 2008).

In fact, one study found that children reunified after an average of 2 years in foster care exhibited considerable behavior problems, including increased legal involvement, substance abuse, and self destructive behavior when compared to their counterparts who remain in foster care. (Taussig, Clyman, & Landsverk, 2001). This is likely due to a number of factors. For instance, the parenting problems that led to the initial placement in foster care may not have been addressed during the separation, resulting in re-exposure to risky home environments (Taussig et al., 2001). This is most notable in cases of parental psychopathology and family violence, which are difficult to remediate and often are not fully resolved by the time the child returns home (Taussig et al., 2001). Other possible explanations for the deterioration of the child's functioning include the reintroduction of external risks such as community violence and poverty that they may have had respite from while in foster care (Bellamy, 2008; Taussig et al., 2001). Thus "a return to fragile home environments, whether introduced by factors within or outside of the family could erode any gains made in foster care" (Bellamy, 2008, p. 218). The behavioral and emotional problems exhibited by children after reunification can at times lead to an additional removal from home and a return to foster care (Bellamy, 2008). With repeated moves and multiple caregivers, these children are at risk for attachment difficulties that can lead to difficulties in interpersonal relationships during childhood and beyond (Gauthier, Fortin & Jeliu, 2004).

However, other studies have shown differing patterns in mental health symptoms for children involved in the foster care system. For instance, one study found that while

children who remained in foster care exhibited more externalizing behavior problems overall, these problems remained stable from baseline to each follow up assessment. In contrast, children in the sample who were reunified with their parents exhibited a significant increase in internalizing problems at each follow up assessment period with a four fold increase at the first follow up (18 months) and a two fold increase at the second follow up assessment (36 months). The authors suggest that that the increase in internalizing problems is related to increased risk factors previously noted, particularly their caregivers' relatively poorer mental health. This suggests that the mental health needs of caregivers should be a target for intervention in order to improve mental health outcomes for children following reunification (Bellamy 2008).

Play Therapy

Play is a natural and developmentally appropriate way for children to problem solve (Ryan, 2007). It allows them to sort through emotionally troubling issues while also serving to restore their sense of fun and hope in the future (Ryan, 2007). Play also allows children to share their wishes and inner thoughts with play companions (Ryan, 2007). These factors make play a rewarding experience and a useful tool for therapists to use to help ameliorate a number of childhood problems.

In traditional play therapy practice, a child is seen individually by a therapist and parents are consulted on a collateral basis. However, a number of therapists and theorists have suggested ways to more fully incorporate parents into the play therapy experience, with some models going as far as teaching parents play therapy techniques to use at home (Ryan, 2007). The involvement of parents in play therapy is thought to be a useful tool to improve attachment. There are several models that include parents which are Filial

Therapy, Family Theraplay and Parent Child Interaction Therapy. Aspects of these methods were also used in the program design.

Filial Therapy

Filial Therapy is a combination of play and family therapy that was developed in the 1960's by Bernard and Louise Guerney (Garza, Watts & Kinsworthy, 2007). The model was intended to be a long term parent training program lasting at least 6 months. The program was later adapted by Gary Landreth and was shortened to a 10 session training model for parents who were unable, for financial and other reasons, to commit to long term therapy (Garza et al, 2007). In this model parents are taught by qualified play therapists to form a therapeutic relationship with their children and become therapeutic agents themselves (Ryan, 2007).

Because play therapy enables children to feel relaxed and more playful it is a very effective way for children to make advances in their development and increase their sense of well-being. It is also a useful tool that enables children to communicate and share a range of emotions with receptive adults, including incompletely processed traumatic and/or abusive experiences. Play is able to facilitate the expression of overwhelming emotion because it is easily accomplished non-verbally, which allows young children to express that which they do not have words for. This makes play an ideal way for caregivers to understand their children's emotional lives. By playing out dysfunctional as well as healthy adult-child relationships, children are able to develop stronger and more adaptive attachments to their caregivers. It is these considerations that are at the heart of the theoretical foundation of filial therapy (Ryan, 2007).

Throughout the process, caregivers are viewed as partners in treatment with the focus remaining on developing positive relationships with their children and not on the problems they present (Ryan, 2007). Filial therapy facilitates the interpersonal and emotional development of children and provides their caregivers with training and experience in a comprehensive set of parenting skills, which are integral to child management skills (Ryan, 2007). These skills in turn play a significant role in the development of secure relationships between the parent and child (Ryan, 2007). Through their training, caregivers are helped to develop the following skills: “verbally structuring or framing a new situation for their children, showing empathic listening skills and verbally reflecting children’s feelings and thoughts as they play, taking part in child-led imaginative play by accepting imaginary roles and playing them out in the ways their children wish within safe boundaries, setting limits to their children’s behavior to keep everyone safe, establish parental authority and helping children become more responsible for their behavior at an age-appropriate level” (Ryan, 2007, p. 647). Goals for children include recognizing and constructively expressing feelings, feeling heard, increasing coping strategies and confidence, developing proactive behaviors and decreasing problematic ones (Garza et al, 2007).

The filial therapy model is a combination of didactic and group process elements. Groups are typically no larger than 8 members and the content is directly related to parents’ concerns about their own parenting abilities as well as experiences about their children and family. The didactic component of filial training emphasizes presenting information in simple teaching points, homework assignments, catchy “rules of thumb”,

and engaging stories and metaphors. Child centered play therapy skills are modeled by the filial trainers and practiced by parents in the group setting (Garza et al, 2007).

Outcome studies have revealed that filial therapy strengthens the parent-child relationship by fostering increased parental acceptance, decreased parental stress and decreased problematic behaviors from children (Garza et al., 2007). This model has been effective both as a preventive intervention and as a clinical intervention with a range of child and family difficulties, including child and family trauma, divorced and reunified families, foster/kinship care, adoption and attention difficulties (Ryan, 2007). The changes produced through filial therapy are typically “more profound and longer lasting”, which is largely attributed to the use of the existing relationship between parent and child (Garza et al, 2007, p. 278). This model has been implemented with a wide variety of cultural groups and has had similar levels of effectiveness (Ryan, 2007).

There are key differences between filial therapy and other parent training models. Other models tend to focus on problem-solving techniques while filial therapy emphasizes the parent child relationship. Filial therapy also places more importance on communication through play rather than through verbalization. This focus on play allows children to fully express their emotions through symbolic expression (Watts & Braddus, 2002).

Family Theraplay

Family Theraplay is meant to improve the parent-child relationship by modeling for parents how to appropriately interact with the child. However, in this model, therapists take a more active role and conduct the majority of play sessions themselves. Theraplay is meant to provide structure, challenge, intrusions and nurturing for children.

In the Family Theraplay model, parents and children participate in 20 sessions where the parent acts as an observer for the first half of the treatment and later as a more active participant in the last half of the treatment program. During sessions the theraplay therapist strives to take charge of the session, to communicate the child's wonderful qualities, protects the child from hurts and cares for scratches, bumps and bruises, and makes eye contact whenever possible (Jerberg, 1984).

During the first 10 sessions, parents sit with an "interpreting therapist" as they observe their child's treatment. This allows parents to see the child's wonderful qualities as well as their "distancing maneuvers". The Interpreting therapist discusses the theraplay strategies and rationale, calls attention to the child's keep away maneuvers, asks about problem areas and successful coping during the past week, gives guidance regarding the week ahead, allows the parents to express any acceptable and unacceptable wishes, fears and fantasies, explores resistances, and refers parents for marital therapy if necessary. During the last 10 sessions, parents typically join the play therapy sessions where they are encouraged to participate in the play and are coached on theraplay techniques (Jerberg, 1984).

Parent Child Interaction Therapy

Parent Child Interaction Therapy is a model that has been used to address a variety of presenting problems with children in numerous family constellations (e.g. foster families, single parent families, etc) (Timmer et al, 2006). The model, developed by Sheila Eyeberg, was originally intended as a therapy for families with behaviorally disturbed children (Johnson, Franklin, Hall & Prieto, 2000). However, it has been shown to be effective with childhood problems ranging from ADHD, separation anxiety,

depression, self-injurious behavior, post-divorce adjustment and abuse, and is best suited for younger children between the ages of 3 and 9 (Johnson, et al., 2000).

Several studies have evaluated the short term effectiveness of PCIT and have found that PCIT was related to a decline in the number and intensity of child behavior problems at home, improved parental attitudes, significantly reduced parental stress levels, improved behavioral interactions between parent and child, and effectiveness with abusive families. Although there are fewer studies of long-term effectiveness, it has been found that children were able to maintain their gains following treatment, parents reported continued decrease in stress when compared to pretreatment levels, and an increased confidence in their ability to manage their child's behavior (Pade, Taube, Aalborg, & Reiser, 2006).

PCIT is conducted in 2 phases, the child-directed interaction phase and the parent-directed interaction phase. The child-directed interaction phase (also known as the relationship enhancement phase) is intended to create or strengthen a positive, mutually rewarding relationship between child and caregiver. The parent-directed interaction phase (also known as the behavior management phase) is designed to teach parents effective parenting skills that can be used to manage the child's negative or acting out behavior. The child directed phase (CDI) is typically conducted over 7-10 sessions and the parent-directed interaction phase (PDI) is conducted over an additional 7-10 sessions. Parents receive training on skills used during these phases and are then "coached" by a child therapist in the use of these skills during dyadic or triadic sessions with their children. This model typically requires the use of an observation room, a two-way mirror

and a “bug in the ear” (a transmitter) that allows the therapist to provide the parent with direction in appropriate use of techniques (Timmer et al, 2006).

Because the PCIT model is fairly resource intensive, it is typically used at clinics affiliated with large university hospitals. However, there has been some research conducted on the effectiveness of PCIT at community based centers where the model has been adapted to meet the needs of organizations with fewer resources. One such study found that short term (10 weeks) PCIT conducted in a multifamily group modality resulted in significant improvement in child behavior immediately following treatment. However, these gains were only modestly retained at a 5 year follow up (Pade et al., 2006).

Similar to filial therapy, PCIT attempts to improve parent-child relationships by teaching parents the fundamental relationship-building techniques used by play therapists. As mentioned above, these techniques are taught during the child-directed interaction phase and include describing what a child is doing; reflecting appropriate speech and feelings, and praising appropriate behaviors (Johnson et al, 2000). Parents are particularly encouraged to increase positive and appropriate statements while decreasing and eventually eliminating statements that result in negative interactions, such as demands, criticism or threats (Timmer et al., 2006). These skills often generalize to situations outside of the special play time parents are instructed to implement and result in a decrease in family stress (Johnson et al, 2000).

During the parent-directed interaction phase parents are taught appropriate discipline practices including establishing the four preconditions for discipline. These include making sure the child knows exactly what they are supposed to do (or not do),

establishing the consequences for misbehavior, ensuring that the child is developmentally capable of doing what he/she is being asked to do, and making sure that the parents' own frustration and anger were under control before carrying out discipline (Johnson et al, 2000).

Each of the play therapy models described above have numerous differences; they have different theoretical foundations and employ different techniques. However, each has at its core a belief that play is therapeutic and can be used to affect change in the child as well as the overarching goal to improve parent-child relationships. However, after careful review of the literature it was determined that the Parent Child Interaction Therapy model would be the most useful in the Attachment Based Parenting Program described in this dissertation. The model's focus on teaching skills for relationship enhancement as well appropriate discipline appeared best suited to meet the needs of the parents at The Family Center. Thus, the principles and techniques of PCIT, were used as part of the group curriculum for the program.

Summary

There are a multitude of factors that can negatively affect the attachment relationship between parent and child (Kobak et al., 2006). Parental mental illness can be particularly harmful to the attachment relationship due to the parents' impairment in the ability to be appropriately responsive to their child's signals (a key factor in fostering secure attachment) (Seifer, 2003). Parental mental illness also places children at risk for removal and placement in the foster care system (Ackerson, 2003). Foster care placement can also impair attachment relationships between parents and their children (Haight, et al., 2003). There are several factors aside from parental mental illness that

can contribute to a child's placement in foster care, such as homelessness, substance abuse, neglect, or child abuse, all of which can place children at risk for poor social emotional outcomes as well as further damage the attachment relationship (Ackerson, 2003; Hoffman & Rosenheck, 2001). The parents at the Family Center have struggled with many of these issues in addition to their own history of trauma.

Attachment is a proximity seeking system wherein the primary caregiver acts as the attachment figure (Feeney, Noller & Roberts, 2000). The various attachment styles (secure, avoidant, ambivalent, and disorganized) stem from differing parenting styles as parents who are securely attached typically raise children with secure attachment and parents with an insecure (avoidant, ambivalent or disorganized) attachment style raise children who are similarly insecurely attached (Howe, 2006; Howe & Fearnley, 2003). A person's attachment style has a significant effect on social emotional functioning throughout the lifespan (Howe, 2006). Several interventions have been designed to assist parents in improving the attachment relationship with their children. It is these interventions, along with principles from play therapy that have been used to inform the curriculum provided for the parenting group described later in this dissertation.

Chapter III

METHODS OF INVESTIGATION

Abstract

This dissertation utilized Maher's (2000) program planning and evaluation framework as well as a case study approach. The following chapter describes Maher's framework, which involves four phases: The Clarification Phase, Design Phase, Implementation Phase and Evaluation Phase. In addition, as is consistent with a case study approach, the chapter also outlines ways in which the consultant gained access to the organization and the process through which the consultant was able to familiarize herself with the relevant context of the organization.

The Four Phases of the Program Planning and Evaluation Framework

Maher (2000) defines a program as a "configuration of resources, organized to add value to an individual, group or organization" (p.2). The aim of this dissertation was to develop such a program with the purpose of adding value to the participants as well as the organization. There are four phases to Maher's (2000) program planning and evaluation framework, which are Clarification Phase, Design Phase, Implementation Phase and the Evaluation Phase. The four phases are separate, but interrelated. These phases will be described in detail below.

Clarification Phase

The first phase of Maher's (2000) framework is the Clarification Phase. The Clarification Phase provides an opportunity to further delineate relevant characteristics of the client and target population. Additionally, within this phase, there are multiple areas assessed, namely the needs of the target population and the context within which the client and target population function. Thus, there are three main activities involved in this phase (1) identifying the target population, (2) determining the needs of the target population, (3) assessing and outlining the relevant context. The information gathered from these activities is used to inform and generate the program design in the following phase.

Identifying the target population

The first activity of this phase involves describing the organization and identifying the target population that is meant to be the recipient of the program. A target population can be an individual, group or organization. In order to specify the target population certain steps must be taken which include determining the size of the population, describing the relevant characteristics of the population (e.g. size, age, gender, race, experience, other), determining a need for segmentation and documenting the target population in a clear and precise manner. Specification of the target population can be achieved through interviews with relevant stakeholders, a permanent product review or a questionnaire. For the purposes of this project, the consultant chose to interview relevant stakeholders in order to specify the target population. Specific details about the target population for this dissertation will be discussed in the following chapter.

Needs Assessment

The next step in the Clarification Phase is to assess the needs of the target population that might be addressed by a program. A need, in the context of this model, is defined as the discrepancy between the current state of functioning (either psychological or educational) of the target population and the desired state of functioning. Thus, in order to understand the needs of the target population, the consultant must gather, analyze and interpret information about the population and their needs and then determine the nature, scope and extent of these needs. This process is known as the needs assessment. Some examples of needs of single parents struggling with mental illness include, parenting skills such as discipline and providing appropriate structure for their children, and the ability to advocate for their own needs as well as the needs of their children, the ability to understand the link between their own difficult histories and their parenting practices.

There are four qualities that need to be present to conduct a sound needs assessment. These qualities are practicality, utility, propriety, and technical defensibility. In order for the assessment to be practical it must be capable of being conducted in the setting and with the target population without disrupting the routines of either the population or the organization. Utility refers to the ability of the needs assessment to produce information that provides direction for the program planning process. Propriety refers to the importance of conducting a needs assessment in an ethical and legal manner. Finally, technical defensibility indicates that the needs assessment uses methods, procedures and instruments that are reliable and valid.

A vital component of the needs assessment process is specifying the domains of target population needs. The primary question to ask in this process is “what are domains or areas of the target population in which need seems to exist having to do with growth, development, and improvement of the target population?” (Maher, 2000, III-10). The domains identified for this dissertation were (1) Psychological Concerns of Parents, (2) Parenting Skills, and (3) Attachment. These domains were determined through careful consultation and interviews with relevant stakeholders. Once the domains are determined, a structure of needs should be developed for each domain. A structure of needs includes needs assessment questions, clearly defined current and desired state of affairs, data collection variables, a delineation of methods and procedures for data analysis and interpretation, communication of results and roles, responsibilities and timelines.

Context Assessment

The final step of the Clarification Phase is to assess and understand the relevant context. It is important to understand that the target population and their needs are embedded in a context that will affect the implementation of a program. There are 8 factors to consider when delineating the relevant context. These factors, known as AVICTORY factors are described below:

- A- Ability of the organization to commit resources to the program
- V- Values of organizational members and other relevant stakeholders
- I- Ideas that stakeholders have about the target population and their needs
- C- Circumstances of the organization related to its structure and direction
- T- Timing of implementing a program within the organization

O- Obligation of organizational members to addressing needs of the target

Population

R- Resistance within the organization to assisting the target population

Y- Yield (or benefit) to the target population of participating in the program

As a consultant to this organization, it was vital to assess each of these issues to understand possible barriers to implementing a program with several stakeholders.

Design Phase

The second phase of the process is the Design Phase and is informed by the information gathered during the Clarification Phase. A clear understanding of the program and its purpose is necessary in order to assess how well the program has been implemented and to what extent the program was able to add value to the target population. The purpose of the design phase is to clearly document the essential elements of the design. The client and relevant stakeholders should be closely involved in the process. There are seven key elements to the program design, which are: (1) purpose, goals and goal indicators; (2) program components, phases and activities; (3) personnel; (4) development and implementation schedule, (5) budget; (6) program evaluation plan; and (7) other relevant program design elements.

The first element of the Design Phase is the most crucial as it is impossible to determine if the program has added value to the target population if the purpose and goals are not clearly delineated. The statement of program purpose specifies who is to participate in the program, how the program will be implemented, and what benefits the participants will receive from the program. The goals of the program should be clearly stated and SMART (specific, measurable, attainable, relevant and time-framed). These

SMART goals allow for the formulation of a program evaluation plan, which provides relevant stakeholders with data about the progress of participants. The specific elements and activities of the program design phase for this dissertation are presented in Chapter V.

Implementation Phase

The third phase of the program planning and evaluation process is the Implementation Phase. The purpose of this phase is to insure that the program is implemented according to the program design. It is important during this phase that implementation is closely monitored by the program design team or other responsible parties and that modification are made as needed. The Implementation Phase involves three major activities. These activities “are sequential, interrelated, and reflexive” (Maher, 2000, p. V-2). The first step is to review the program design to determine if it has been developed and is ready for implementation. The next step is to facilitate the program implementation and the final step is to monitor the program process.

For the purposes of this dissertation, the first step involved reviewing the program purpose and goals and program design elements to ensure that they are appropriate and relevant to the context. In order to facilitate the program implementation for the project described in this dissertation, the consultant discussed the program with relevant stakeholders involved with the implementation. The consultant oriented staff at the organization to the program and solicited their help in recruiting members of the target population to participate. The consultant gathered information from the staff as well as members of the target population about their needs and what they wished to gain from participation in the program. The consultant also met with staff members about design

elements and collaborated with specific staff members on implementing the psychoeducational group. A program implementation checklist was designed to monitor the program process. The checklist was designed to track when and if specific program design elements were implemented.

Evaluation Phase

The final phase of the program planning and evaluation process is the Evaluation Phase. The purpose of this phase is to gather and analyze data to determine the value of the program. This process contributes to further program development and improvement. A program evaluation plan, as with a needs assessment, must be practical, useful, proper and technically defensible. There are several activities in the Evaluation Phase. These activities include, identifying the client, determining the client's need for program evaluation, placing the program in evaluable form, identifying program evaluation questions, specifying data collection variables for the questions, describing the data collection and analysis process, delineating program evaluation personnel and responsibilities, determining guidelines for communication of information gathered, creating program evaluation protocols, implementing the evaluation and evaluating the program evaluation.

The program evaluation plan for the current program included three questions, namely (1) who participated in the program?; (2) how was the program implemented with respect to participants?; (3) what appears to be the benefit of the program to participants? Data gathered to address these questions allow the consultant to make determinations about the value of the program. In addition, data gathered during this phase can provide

information on how to improve the program for future implementation at the organization.

Gaining access to the organization

Entry into the organization

My entry into the organization began several years ago when I accepted a position as a practicum student at one of the organization's mental health clinics. From 2005-2006, my work at the mental health clinic involved providing individual therapy to children, adolescents and adults. Following this experience, I accepted another position in the organization as a practicum student in the evaluation department. From 2006-2007, I worked with the staff of the evaluation department to restructure the mental health and substance abuse services offered to Mentally Ill/Chemically Addicted population.

Through my work in the evaluation department I gained valuable experience that also helped shape the focus of my dissertation. I became interested in using a program design and evaluation framework to provide services to children and families. Thus, I consulted with the evaluation department about the possibility of providing such a service to the families served by the agency. We discussed the needs of the families served by the agency and worked to identify a need that could be addressed using the program design approach. Through consultation, we determined that the residential facility that serves single parents with a history of mental illness could benefit from a program to address the noticeable attachment issues between parents at this facility and their children.

In order to gain approval for the project, a meeting was arranged with the Administrator overseeing the program and Director of Evaluation. The Senior Administrator expressed the belief that the project was worthwhile and provided approval.

Introduction to the residential facility

After careful discussion with the program design and evaluation staff, I was introduced to the program director of the facility to discuss the possibility of implementing a program at the residence. The program director was supportive of the notion from the outset as she had previously identified the need for such a program, but did not have the resources to design and implement it at the time. During this time, I gathered information from the program director about the target population and the residence. In order to further my understanding of the relevant context, I also attended monthly staff meetings, which allowed me to further understand the services offered at the residence as well as the challenges and needs of the target population served. My attendance at these meetings also provided an opportunity to interact at times with the residents of the facility.

During this time, I also continued to consult with the administration at the facility regarding the program design and purpose. Those in attendance for these meetings included a Senior Administrator, the Program Director, and Clinical Specialist. At these meetings we discussed ways to recruit participants, and the format with which the program would be implemented (i.e. group vs. individual). After participating in the staff meetings and consulting with administration, I began to formulate a plan to conduct a

thorough needs assessment to further determine the needs of the target population. The needs assessment is discussed in depth in Chapter IV.

Summary

Maher's (2000) program planning and evaluation framework was used for this dissertation. There are four phases to this model: The Clarification Phase, Design phase, Implementation Phase and Evaluation Phase. The Clarification Phase provides an opportunity to further delineate relevant characteristics of the client and target population. Additionally within this phase there are multiple areas assessed, namely the needs of the target population and the context within which the client and target population function. The findings from this assessment are used to generate a program design (i.e. an intervention) in the program design phase. The program design is clearly delineated and all aspects of the program are considered, including goals, components, staff participation, budgetary issues and so forth. Following this, the program is implemented and there are procedures put in place to monitor whether the program is implemented properly and any adjustments are made along the way if deemed necessary. Finally, the program is evaluated to determine whether it reached its goals (Maher, 2000).

In order to utilize this approach, the consultant had to gain entry into the organization. For this dissertation, entry into the organization began with my work as a practicum student. Through my continued interactions with the organization via practicum placements, I was able to identify a need of the organization and develop a program to address it. Approval for the program was granted to conduct this dissertation project by meeting with relevant administrative staff. An understanding of the context was achieved via meetings with administrators at the facility as well as through

participant observation at staff meetings. Consultation with staff members at the facility also provided useful information for program design.

CHAPTER IV

CLARIFICATION PHASE

Abstract

This chapter details the first phase of the program planning and evaluation process, the Clarification Phase. This chapter includes four main sections (1) Introductory Information, (2) Target Population Description, (3) Needs Assessment, (4) Context Assessment. These sections provide a description of the organization, the population served in the program, an assessment of the needs of the target population, and an explication of the relevant context of the organization.

Introductory Information

Client

The identified client for this project was the Former Director at the Family Center, which is part of a not-for-profit community organization in a large metropolitan city. The client served as the director of the Family Center for eight years. In August 2008, she was promoted from her position as Director of the Family Center and was a full time employee. Despite her promotion, she was still very involved with the operation of the Family Center. In fact, it was the client who identified the need for programming to address the parenting and attachment based needs of the target population.

Given her position at the community organization, the client was the appropriate person to serve as the identified client for this process. However, there were other administrators that were involved in the program planning process at various phases. These include the Current Director at the Family Center; the Clinical Specialist working in the Family Center; a Senior Administrator; the Director of Best Practices; and the Senior Management of the Evaluation Department.

Organization

The community organization is a not-for-profit organization that serves people with developmental disabilities and serious mental illness. This organization aids the population by providing mental health, health and residential services. The agency serves a large urban population.

Of the numerous programs at the community organization, there was one in particular identified for program planning and evaluation services. This program is called the Family Center. This center is a community that consists of apartments for single-parent families and for single adults. There is support provided for residents 24 hours a day and a number of service professionals who work to help consumers reach their goals. These include case managers on staff who work individually with residents, a program teacher who provides group counseling, an entitlements counselor who works with residents to help them obtain necessary benefits (e.g. public assistance, SSI), child care workers who provide day care services, and a tutor who provides academic assessments and homework help for the school age children who reside in the apartment complex.

Target Population Description

The population at the Family Center consists of single parents with a history of homelessness and mental illness that have been recently reunified with their children. This information was obtained from documents detailing admissions criteria for the center. Further (and more specific) information about the current residents of the Family Center was obtained through an interview with the client (see appendix A).

Family characteristics

Size/Frequency

The size of the target population is important to note as it is necessary to know the number of people that will potentially be serviced. At the time the Clarification Phase was completed there were 18 families that resided at the Family Center. The majority of the families were composed of one parent and one child; however, these families were allowed to have a maximum of two children living in their apartment.

Table 1
Family Constellation

	Families with one child	Families with two children	Number of families	Number of children
Total	13	5	18	23

Age of children

There was a rather wide range in age for the children in the program. They ranged from newborn to age 16 with the average age being 7 or 8. The age of the children was very important as it indicated a possible need for segmentation. This information was used to determine if the program design had to be tailored to the developmental level of the children. Thus it was determined that the population could be segmented into the following age group categories:

1. Families with children ages 0-3
2. Families with children ages 4-5
3. Families with children ages 6-11
4. Families with children ages 12-18

Families with children that fall within these different age ranges likely have different needs, thus the consultant considered the possibility that the program needed to be adapted to address specific developmental issues.

Ethnic Background

It is important to remain culturally sensitive and to have an understanding of cultural variations that may influence family functioning, which could potentially affect the outcome of any program designed. Therefore, information about the ethnic background of the families was collected.

Table 2
Ethnic background

African American	Latino	Caribbean	Caucasian
12	3	2	1

Parent characteristics

Demographics

Table 3
Parent demographics

Average age	Number of females	Number of males
25	16	2

Psychological functioning

As stated previously, all parents in the program had a documented mental illness. They met criteria for the classification of Severely and Persistently Mentally Ill. The most common diagnoses of the parents were Schizophrenia, Bipolar Disorder and Major Depression; in addition, at least 6 of the parents had a history of substance abuse. This

information is important to note as the parents' mental health concerns can affect their ability to parent and their interactions with their children. Further assessment of the role mental health played in parenting interactions amongst the target population was conducted during the needs assessment to determine if this factor would be considered in the program design

Needs Assessment

Needs Assessment Domains

A needs assessment was conducted in order to customize the design of the parenting program. Initially, the consultant met with the client and discussed areas of concern for the target population. The information gathered in this interview was utilized to establish the appropriate domains and structure of needs for the assessment protocol. Information generated from the needs assessment protocol was utilized to create a semi-structured interview that was administered to staff at the Family Center.

Three main domains were identified for the needs assessment. These domains were Psychological Concerns of Parents, Parenting Skills, and Attachment. These domains were further subdivided. The Psychological Concerns of Parents domain was related to the mental health needs and issues of the parents who resided at the Family Center. It was presumed that these concerns had an impact on the residents' ability to parent their children. The Parenting Skills Domain was related to the skill set necessary to raise children. The Attachment domain was related to the bond that typically exists between parent and child. Based on discussions with the client, it was presumed that this bond has been fractured due to prolonged separation and parental mental illness. It was understood that while each of these domains was important, not all was included in the subsequent program design.

Protocol I

Domain: Psychological Concerns of parents

Table 4
Relationship with Their Own Caregivers

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of affairs
To what extent do parents struggling with a mental illness need to process their own history of poor parenting?	Parents' own history of poor parenting interferes with their ability to properly parent.	Parents' understand the poor parenting practices they inherited from their own caregivers and no longer allow them to interfere with their own parenting

Data Collection Variables

- Able to identify parenting practices of their own caregivers
- Able to identify and articulate the effects these parenting practices had on them as children
- Able to identify similarities in their own parenting practices and any negative effects they have on their own children
- Able to identify ways in which they are different from their caregivers
- Able to learn more appropriate parenting skills
- Able to put the more appropriate parenting skills into practice

Data Collection Methods, Instruments, Procedures

In order to answer each needs assessment question, the consultant conducted an interview with staff members at the Family Center. It was determined after conferring with the client that individual interviews were the best option to gather data. Staff members were interviewed because they work closely with the parents and children who reside at the Family Center and have a thorough understanding of the target population's current level of functioning.

- Individual interviews were conducted with 7 staff members.
- The interview was a combination of the formal and informal approach.
- Each interview was tape recorded (with the permission of each staff member interviewed).
- A copy of the interview questions is included in Appendix B.

Methods and Procedures for data analysis and interpretation

As mentioned above, data was gathered utilizing an interview. The goal of this process was to identify deficits in the target population and the concrete skills that staff believed residents needed to learn to address these deficits. See Table 5 for further details.

Table 5
Data Analysis and Interpretation Steps

Steps	Tasks
Step I	Interviews were transcribed
Step II	The data collected was organized by question
Step III	The consultant compiled answers from all participants, noting similarities and differences in their answers.
Step IV	The consultant identified, analyzed and discussed themes throughout the interviews and their implications for the program design task.

Guidelines for Communication and use of Needs Assessment Information

The results of the needs assessment were communicated to the client as well as to other key administrators involved in the program planning process (see client description for a complete list of key stakeholders). These key stakeholders received a written report detailing the answers to each needs assessment question. In addition, the consultant met with stakeholders to review the report.

Roles, Responsibilities, Timelines

In order to implement the needs assessment, the consultant worked closely with the current Director of the Family Center who was instrumental in coordinating staff schedules so that that they were able to participate in the necessary interviews. She also assisted in explaining the purpose of the needs assessment. See Table 6 for further details.

Table 6
Timeline for Communication of Needs Assessment Results

Dates	Tasks
March 2008	Needs assessment interviews conducted
April 2008	Needs assessment report completed
April 2008	Needs assessment meeting with key stakeholders to review report and determine how to utilize the information in the program planning process

Protocol II

Domain: Psychological Concerns of parents

Table 7
Parents' Mental Health

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
To what extent do the parents need to learn how to manage their mental illness so that it does not interfere with their ability to parent?	Parents' own mental illness interferes with their ability to parent their children	Parents' own mental illness does not interfere with their ability to parent their children.

Data Collection Variables

- Parents are able to identify ways in which their mental health concerns interfere with parenting
- Parents are able to manage the symptoms of their mental illness (e.g. by regularly attending therapy, taking medications on a regular basis)
- Parents are able to identify when they need assistance and reach out to appropriate people (e.g. case managers and other staff members of The Family Center)

Protocol III

Domain: Psychological Concerns of parents

Table 8
Reunification Process

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
To what extent do parents need to identify and process the effect that reunification has had on the relationship between themselves and their children?	Emotional issues brought up as a result of the reunification process affects their ability to parent their children	Parents' emotional issues related to the reunification process do not affect their ability to parent their children.

Data Collection Variables

- Parents are able to identify ways in which the reunification process affects their parenting
- Parents are able to discuss their struggles related to the reunification process

*Protocol IV**Domain: Parenting Skills*

Table 9
Discipline

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
What skills are needed for parents to appropriately discipline their children?	Parents at The Family Center do not know how to appropriately discipline their children	Parents know how to appropriately discipline their children

Data Collection Variables

- Parents at The Family Center are able to set clear limits with their children
- They are able to establish appropriate consequences for misbehavior (i.e. consequences that do not include physical punishment)
- Parents are able to provide positive reinforcement for good behavior

*Protocol V**Domain: Parenting Skills*

Table 10
Appropriate Structure

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
What skills are needed for parents at The Family Center to provide structure for their children?	Parents are unable to establish structure for their children	Parents are able to establish structure for their children

Data Collection Variables

- Parents are able to get their children to school on time
- They are able to establish and maintain appropriate bedtimes for their children
- Parents are able to ensure that homework is completed
- Parents are able to establish consistent dinner time schedules

Protocol VI

Domain: Parenting Skills

Table 11
Advocating for Educational Needs

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
In what ways do parents need to learn how to effectively advocate for their children's educational needs?	Parents are unable to effectively advocate for their children's educational needs.	Parents are able to effectively advocate for their children's educational needs.

Data Collection Variables

- Parents attend all parent/teacher meetings
- Parents know the name and contact info of relevant school staff members
- Parents have a basic understanding of grade promotion
- Parents are aware of their rights
- Parents are able to seek help from third parties (e.g. The Family Center staff, parent advocates) when needed

Protocol VII

Domain: Attachment

Table 12
Emotional Connection

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
What affective skills are needed for parents to possess to help them connect with their children?	Parents struggle to connect emotionally with their children	Parents are able to emotionally connect with their children

Data Collection Variables

- Parents are able to show their children physical affection
- Parents are able to empathize with their children's feelings
- Parents are able to recognize when their children need to be comforted and reassured
- Parents are able to provide comfort and reassurance to their children when needed

Protocol VIII

Domain: Attachment

Table 13
Separation

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
To what extent to parents at The Family Center need to learn to separate from their children	Some parents at The Family Center have difficulty separating from their children even when it is necessary/appropriate	Parents do not have difficulty separating from their children

Data Collection Variables

- Parents are able to tolerate temporary separations from children
- Parents are able to manage their anxiety when temporarily separated from children
- Parents are able to understand and articulate their difficulties with separating from their children

Protocol IX

Domain: Attachment

Table 14
Active Involvement in Childcare

Needs Assessment Question	Initial Perception of Current State of Affairs	Desired State of Affairs
In what ways do parents at The Family Center need to increase their involvement in child care?	Parents are not actively involved in their child's care	Parents are actively involved in their child's care

Data Collection Variables

- The parents who struggle with being actively involved in child care will utilize the child care services of The Family Center less frequently

*Protocol X**Domain: Attachment*

Table 15

Engagement in Play

Needs Assessment Question	Initial Perception of the Current State of Affairs	Desired State of Affairs
To what extent do parents need to learn how to engage in play and other positive activities with their children?	Parents are unable to engage in play and other positive interactions with their children	Parents are able to engage in play and other positive interactions with their children

Data Collection Variables

- Parents are able to understand and articulate why it is important to engage in play with their children
- Parents are able to identify play activities that they will engage in with their children
- Parents will identify other positive activities to engage in with their children
- Parents will increase the amount of time they play with their children
- Parents will increase the number of outings/trips they go on with their children

Needs Assessment Results

Domain: Psychological concerns of parents

Question 1: To what extent do parents struggling with a mental illness need to process their own history of poor parenting?

Interview responses indicate that each parent at the Family Center experienced a number of stressors in childhood (e.g. foster care placement, abuse, neglect). Many of the parents also had poor models for parenting. Thus, their childhood experiences have impacted their parenting practices in a variety of ways. Some parents become overprotective in an effort to prevent their child from experiencing the pain they have experienced while others repeat the problematic patterns they experienced with their own children. However, other parents are able to parent in a positive and consistent manner despite their trauma history. It appears that at least some of the parents at the Family Center would benefit from processing their own history of poor parenting in order to address the negative ways in which it influences their parenting practices. This may be difficult for some parents to do as they typically do not speak about these issues with staff members at The Family Center.

Question 2: To what extent do the parents need to learn how to manage their mental illness so that it does not interfere with their ability to parent?

Most parents at Family Center attend individual therapy and are on psychotropic medications, which they take regularly. Each staff member noted that when the parents' symptoms are under control, their parenting is not affected by their mental illness. It appears that parents at the Family Center are quite adept at managing their symptoms and asking for assistance when they realize they are becoming symptomatic. The few parents

who struggle to manage their symptoms or do not recognize when they are becoming symptomatic are monitored by staff and receive assistance when warranted. Thus, it seems that parents do not need to learn how to manage their mental illness as they are able to do so, and there is already a mechanism in place to assist parents who are not able to do so.

Question 3: To what extent do parents need to identify and process the effect that reunification has had on the relationship between themselves and their children?

The reunification process is often emotionally taxing and difficult for both parent and child. Interviews with staff members have highlighted a number of issues that arise as a result of the reunification process. Separation from their children and the eventual reunification results in a considerable amount of stress for parents and affects the manner in which they interact with their children. Additionally, reunification affects the parents' ability to provide appropriate structure and discipline. Many parents struggle to discipline their children either because they fear possible sanctions and another removal, or because they feel guilty about the separation and become overly permissive.

Not all parents respond in this manner to the reunification with their children. Some parents become overwhelmed with the reintroduction of the parenting task and the challenges it presents; thus, they tend to become easily frustrated and harsh with their children. Parents who struggle in this manner often have difficulty managing their anger when upset with their children, which leads them to speak in inappropriate ways to their children. Other parents come to the realization that they are not yet ready to care for their children, which at times results in the difficult decision to return their child to foster care.

Many staff noted during the interview that parents are often not forthcoming about their parenting difficulties either because they fear judgment or worry that their children will be removed again. This is of course a major barrier to parents receiving the help they need. Overall the results from this assessment indicate that the reunification process produces considerable stress for parents. Thus, it appears that they would benefit greatly from the opportunity to discuss these issues and receive support with the challenges they face.

Domain: Parenting Skills

Question 4: What skills are needed for parents to appropriately discipline their children?

Parents at the Family Center struggle to discipline their children appropriately. They are aware that they should not hit their children, but are often at a loss as to what to do in lieu of physical punishment. There are a number of negative or problematic discipline practices the noticed by the staff. These include: screaming and/or cursing at the children and or calling them names. This concerns many of the staff members as the practice is not effective and is often hurtful to the child. Conversely, some parents do not discipline their children at all. According to staff, this permissiveness can occur for a number of reasons including guilt about the separation or lack of confidence in their ability to follow through and provide consistent boundaries for their children. This results in their children becoming the “head of household” and increases their behavior problems.

Given these difficulties, there are a number of skills the parents need to learn. These skills include: learning how to appropriately manage their affect so that they can communicate with their children without screaming, yelling or name calling, and how to

set appropriate limits. They would also benefit from a better understanding of developmental issues and how these issues should affect the way they interact with their children, their expectations for the child's behavior and the discipline practices appropriate for them.

Question 5: What skills are needed for parents at the Family Center to provide structure for their children?

According to staff, most of the parents at the Family Center are able to provide appropriate structure for their children in certain realms. For instance, the majority of parents are able to prepare their children for school and pick them up from school. However, only about half of parents provide consistent meal and bed times for their children. In addition, only half help them with their homework on a regular basis. Thus, approximately half of the parents at The Family Center need assistance in learning how to create more structure in the home around areas of meal and bed times and regular completion of homework.

Question 6: In what ways do parents need to learn how to effectively advocate for their children's educational needs?

A number of parents at the Family Center could benefit from training on the appropriate way to interact with their children's schools and how to advocate for their children's educational needs. Many of the parents are overprotective and worried that their children will be stigmatized because of their parent's mental illness. Thus, they tend to be defensive and at times verbally aggressive with school staff. They often do not follow teacher recommendations and deny when their children have a problem. This results in parents being ineffective advocates for their child and prevents their children

from receiving the help that they need. Fortunately, the Family Center has a tutor on staff that is excellent at interacting with schools and is a valuable resource for the parents. She often acts as a liaison between the school and the parents. However, the parents might benefit from some intervention (either in a group or individual format) that provides them with the skills they need to interact appropriately with their children's schools on their own and also allows them room to discuss their feelings of anxiety about the potential stigma that their children face.

Domain: Attachment

Question 7: What affective skills are needed for parents to possess to help them connect with their children?

Many parents at the Family Center struggle to connect emotionally with their children. For instance, some parents have difficulty being affectionate with their children while others struggle to understand their children's feelings. Thus many parents are unable to interact with their children in a warm, empathic and affectionate manner. In addition, some parents have difficulty recognizing when their child is in distress and comforting their children when necessary. Many parents also need to develop an understanding of how their words impact their children as the parents can often be verbally aggressive towards their children. This verbal aggression and affect dysregulation can damage their already fragile bond with their child. Thus, these parents would benefit from the opportunity to explore this issue in order to increase their understanding of the reasons for these limitations. In addition, the parents would benefit from learning skills to improve the connection between themselves and their children.

Question 8: To what extent do parents at the Family Center need to learn to separate from their children?

The majority of parents at the Family Center do not have difficulty separating from their children. However, there are a few parents who struggle with this issue and tend to be overprotective, which can affect their child's ability to explore the world and grow. Thus, this small number of parents likely need assistance in understanding their reasons for being overprotective and identifying strategies to help them take a step back and allow their children the opportunity to grow and explore.

Question 9: In what ways do parents at the Family Center need to increase their involvement in child care?

Most parents at the Family Center are not consistently involved in childcare. Some use the services on a regular basis but do not participate in activities themselves. Others use the services sporadically at a detriment to their child who could benefit from increased interaction with peers, and homework assistance. A few parents participate on a regular basis and others participate only when there is a special event. Staff would prefer that parents utilize the service consistently and participate more frequently. Some steps have been taken to encourage parents to increase their involvement in the childcare services. These attempts have not always been successful; consequently, there is a need to increase involvement in childcare and to identify other methods of encouraging parents' participation.

Question 10: To what extent do parents need to learn how to engage in play and other positive activities with their children?

Some of the parents at the Family Center are able to engage with their children in a playful manner and plan fun activities for them to participate in. However, only about half of the parents do this consistently. The remaining parents are less consistent about engaging their children in fun, positive or playful activities and often resort to sitting their children in front of the television. This may decrease the parents' opportunities to experience positive interactions with their children. It seems that some of the parents could use assistance in identifying positive and interactive activities to engage in with their children to help enhance the bond between themselves and their children.

Context Assessment

Purpose of Context Assessment

In order to design and appropriate program for the target population an understanding of relevant contextual factors is necessary. Thus a context assessment was carried out using the AVICTORY approach. The methods used to carry out the assessment include interviews with key stakeholders and participant observation. The interviews were conducted with the current director of the Family Center and the client.

Contextual variables

The AVICTORY approach addresses eight key variables which can be used to assess context; these are ability, values, ideas, circumstances, timing, obligations, resistance and yield. Below each relevant variable will be addressed and detailed to assess the context for the program design.

Ability

The ability of the Family Center to commit resources to the program design and implementation process was limited. Major categories of resources include human, technological, informational, physical, financial and temporal.

Human Resources

There were limited human resources available to assist in the program design, implementation and evaluation process. While there were numerous individuals interested, involved in and supportive of this process, none of these individuals had a great deal of time to devote to this specific project.

There were also individuals at the Family Center who were involved in the process, but difficulties with scheduling meetings with them illustrated their limited

amount of time. This was largely due to changes occurring at the Family Center. The three individuals who were able to provide assistance and supervision in the process were the client, the former director and the clinical specialist. Unfortunately, the client's recent promotion led to a decrease in the amount of time she was able to spend on site. The former director was committed to the process and was more available for meetings. The Clinical Specialist of the Family Center, who was present at the outset of the project also provided some consultation in the beginning. Unfortunately, this person left on sick leave and eventually left her position permanently.

An interview with the current director resulted in the identification of possible staff members who would be involved in implementation of the program. One staff member in particular whose role included running process and support groups for the residents of The Family Center was identified as a useful source of support.

Technological/Informational resources

The client was interested in the design of a group intervention. This is important to note as the organization already had a mechanism in place for running groups. For instance, they run groups every fall, spring, and summer, have staff designated to run the groups and have specific times set aside throughout the week to run the groups. In terms of informational resources, there were materials for a parenting group that could have potentially been incorporated into the attachment group they wished to design.

Physical Resources

Physical resources are limited. They do not have specific office space for the consultant to work in. However, there is space available to implement the group intervention as all groups are held in their conference room.

Financial Resources

The full extent of the financial resources of the Family Center was not known at the time of the context assessment. As the staff designated to supervise and implement the program are already salaried employees of the community organization, no additional financial resources are needed to pay them.

Temporal Resources

Time commitments varied depending on the phase of the process. For instance, staff and supervisors had limited time to commit to the program design and curriculum development process. The staff was available to participate in the needs assessment process. As mentioned previously, the needs assessment involved a series of individual interviews with the 11 staff members of The Family Center. The interviews took approximately an hour to complete; thus each staff member committed an hour to the needs assessment process.

It was assumed at the time of the context assessment that the client and staff members of The Family Center would commit considerable more time to the implementation of the program. Groups at The Family Center typically run for 12 weeks and are an hour and a half long. Given the limited amount of time the staff has, the preparation time for each group was anticipated to likely total 30 minutes a week. It was estimated that the time committed to implementation would be approximately 24 hours over a 12 week period (see table 16 for review of estimated time commitment).

Table 16
Estimated Time Commitment

	Needs Assessment	Program Design/Curriculum Development	Preparation	Group Time	Evaluation
<i>Supervisors</i>	0	6	0	TBD	TBD
<i>Staff</i>	11	0	6	18	TBD
<i>Consultant</i>	22	18	6	18	TBD
<i>Total</i>	33	24	12	36	TBD

Values

The traditional and current values of the Family Center are to serve the target population of families that reside there. It has always been important to provide quality service to this target population, particularly since it is such an underserved one.

Other values particularly important to the Family Center are professional growth and development. As such, staff at the Family Center participates in trainings throughout the year to improve their skills. In addition, close attention is paid to the high incidence of burnout in the staff. Administrators have taken efforts to provide additional supports for the staff (e.g. regular meetings to process their concerns about the program and clients, opportunities to highlight the successes of the program rather than focusing on the failures).

Ideas

There were varying degrees of clarity about the task to be accomplished. The staff of the program design and evaluation department had a clear sense of the process and understood each step that must take place to complete the task. However, many staff members of the Family Center were new to this process and were dealing with major changes within their Center at the same time. They did have an understanding of what

the end result would be (e.g. a group designed to address the attachment related needs of the target population).

It was apparent that all stakeholders involved were aware that while quality service had been provided to the target population, there were some gaps in service that need to be addressed. In fact, relevant stakeholders felt that this task has been long overdue.

Circumstances

As stated previously, the Family Center was undergoing a period of transition. The changes began in August 2007 when the client was promoted from her position. A new director was hired to take her place. Unfortunately this person left the position shortly thereafter. Following her departure, a staff member of the Family Center was promoted from her position to Director of The Family Center. At the time of the context assessment it was unclear how long she would remain in this position and at what stage the agency is in their hiring process for a permanent replacement. In addition, the clinical specialist present at the time of the context assessment was out on sick leave and eventually left her position. Thus, at the time of this assessment it was clear that the leadership at the Family Center was in flux. However, the client (and former director) retained an office on site in order to maintain some stability and the organization's mission and strategic plan were unchanged and remained in force.

Timing

As mentioned previously, key administrators had limited time to commit to the program design process. They provided time to conduct the needs assessment, but were less available during the design phase. They were able to commit some time to the implementation process.

There are funds available to pay relevant staff to implement the program, but there are limited funds for additional materials needed for the program. The financial resources needed to maintain the Family Center are obtained through a variety of city and state funds.

The changes in leadership at the Family Center suggest a potential problem for the design and implementation of the program. The client and the current Director of The Family Center appeared open to the process and were willing to allow it to go forward. However, there was a chance that any more changes in the leadership could have hindered the progress of the project.

Obligations

It was clear that outside advocates (i.e. administrators at the community organization) were active supporters of a programmatic approach with the target population. In addition, the other administrators involved (i.e. the client and director) are supporters of any process that would address the needs of the population. However they and some of the program staff were less familiar with, and more cautious regarding the program design model being proposed. It is important to emphasize that they remained much invested in providing quality service to their target population.

Resistance

Despite the commitment to providing quality service to the target population, there was some resistance to the program design process. This was evidenced by the difficulty the consultant had in meeting with the client. This was likely a combination of many factors including her busy schedule and increased responsibilities.

While the director had granted permission to conduct the needs assessment interviews, it was possible at the time of the context assessment that staff may have felt that many other demands were placed on their time. Other possible points of resistance that were considered at the time of the context assessment included concerns about the budget, and participation of the target population. In addition, members of the target population might have been resistant to participating in the group once it was designed and ready to be implemented.

Yield

There was considerable benefit to the Family Center as a consequence of the program. As mentioned, all stakeholders were invested in providing quality service to the target population. Thus the client and other administrators viewed the program as an opportunity for growth and development of the target population. In addition, if the program was successful, it would benefit the reputation of the Family Center within the larger community organization. However, a potential drawback of the program was that it might result in an increase in paperwork and other administrative duties. This is a common drawback for any new initiative.

Summary

The target population consists of single parents with a history of homelessness and mental illness that have been recently reunified with their children. All parents have been classified as Severely and Persistently Mentally Ill. The target population was segmented based on the age/developmental level of the children.

A needs assessment has been designed, and conducted. The needs assessment covers three domains; Psychological concerns of parents, Parenting skills, and Attachment. These domains were further subdivided and needs assessment questions were posed related to the subdivided domains.

A thorough investigation of the context using the AVICTORY framework illustrates that there are some possible obstacles to the program design, implementation and evaluation process. These include resistance from some stakeholders and limited financial resources.

CHAPTER V

PROGRAM DESIGN PHASE

Abstract

This chapter delineates the program design that was created prior to program implementation. The program design is based on data gathered during the Clarification Phase. The Design Phase is the second phase of Maher's (2000) program planning and evaluation framework. The Design Phase includes several elements, goals, purpose, eligibility criteria, policies, inventory and components of design, budget, personnel, and the program evaluation plan. Each of these elements will be described in detail.

Statement of Program Purpose and Goals

Purpose

The population of the Family Center consists of single parents with a history of homelessness and mental illness that have recently been reunified with their children. A portion of these individuals participated in the program. On a weekly basis, over the course of 12 weeks, the participating parents attended a parenting group designed to teach parents about attachment related issues. Through this program, parents learned ways to improve attachment and bonding between themselves and their children.

Goals

Each goal specified is based on the needs assessment protocol. Selected domains of the needs assessment were chosen as a focus for program design. These domains include Psychological Concerns of parents, and Attachment. These domains were determined by the client to be the most relevant for the program design process.

- Participating parents are able to identify and articulate the parenting practices of their own caregivers and any ways in which these practices have influenced the way they parent their own children.
 - This understanding will be articulated in group discussions.
- Parents are able to identify ways in which their mental health concerns may interfere with their ability to parent
 - By the end of the 12 week program participation period, parents will be able to clearly state in group discussion at least one way in which their mental illness impacts their parenting abilities
- Parents will be able to identify ways in which they are able to connect emotionally with their children and ways they are not able to do so.
- Parents will be able to identify and articulate at least one step they can take in improving their emotional connection with their children
- Parents will be able to articulate at least one reason why it is important to engage in play with their children
- Parents will be able to identify at least one play activity that they will engage in with their children by the end of the 12 week program period

- Parents will learn and articulate an understanding of appropriate discipline practices

Eligibility Standards and Criteria

A parent is eligible to participate in the program if he/she meets the following standards and criteria:

- Is classified as severely and persistently mentally ill
- Has already been reunified with their child(ren)
- Has been referred by their case manager
- Has participated in the program's orientation session
- Possesses a documented need in agreement with the determined needs of the target population
- Is in their own individual psychotherapy and attends regularly

Policies Statement

The following is a list of policies and procedures for the program:

1. Only parents who meet all criteria for entrance into the program can participate.
2. Parents will be referred to the program by staff members.
3. Because of the amount of material presented in each session, parents may not miss more than 3 of the 12 sessions.
4. Parents will respect themselves and others in the group
5. Parents will respect the confidentiality of those in the group.
6. During meetings parents are to participate and complete activity assignments.
7. Parents will be willing to accept feedback from others without becoming verbally or physically aggressive/defensive
8. Parents will receive a certificate upon completion of the group.
9. At the conclusion of the program, parents are to complete the parent questionnaire.

Inventory and Components to Program Design

There will be multiple components or phases to the program design process. These components include orientation of staff to the program, recruitment of parents to participate in the program, and the parenting group. Each phase will be explained fully.

Component I: Orientation of Staff to parenting group

In order to begin the parenting group, staff members who interact with the parents must have an understanding of the group and its purpose. If the staff members have a clear understanding of the staff and their purpose, they will be able to help explain the group to the consumers on their caseload and will be able to refer appropriate consumers

to the group. This orientation will take place during a regularly scheduled staff meeting for convenience.

Methods

A written handout will be used to orient the employees to the meeting and its purpose. Verbally explain the purposes and goals of the parenting group.

Technique

Staff members are encouraged to ask questions about the parenting group.
Encourage staff members to express opinions about the group.

Procedure

Staff will be oriented to the meeting, then provided with a brief overview of the purpose and goals of the parenting group and a sample of materials to be used during the group.

Materials

Staff will receive a written handout that includes an overview of the program, its purpose and goals. This material is meant for the personnel to review. It is presumed that the handout will be a useful tool in helping staff understand the program and will increase the likelihood of the staff to be able to explain the program adequately to their consumers (See Appendix C for copy of handout).

Equipment

There is no specific equipment needed for this phase of the program.

Facilities

This meeting will take place in the staff lounge at the Family Center. This is the room most commonly used for staff meetings.

Incentives

The incentive for involvement with this phase of the program is non- monetary. Employees will be motivated to participate in this phase of the program because it will make it easier for them to explain the program to the parents.

Personnel

Table 17
Component I: Personnel

Role	Role Accomplishments	Responsibilities	Relationships
Administrator	Staff members have an understanding of the parenting group and their role in it	- run staff meeting - inform staff about the parenting group	- with consultant - with staff - with supervisors
Consultant	Administrator and staff have an understanding of the parenting group and their roles in it.	- meet individually with administrator to discuss parenting group and related issues - listen to programmatic concerns of the administrator - attend staff meeting to help answer any questions about the parenting group	- with administrator - with staff

Sequencing of Activities

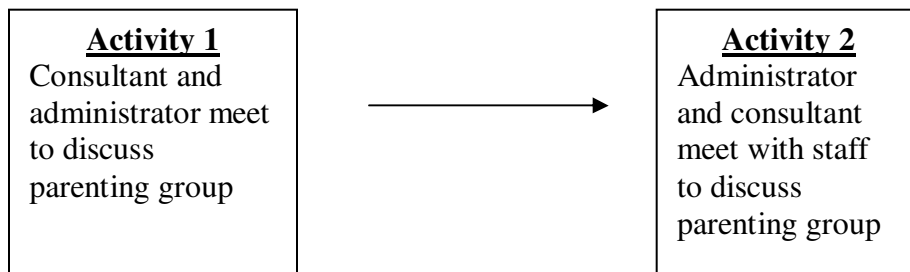


Figure 1. Sequencing of activities for component I.

Component II: Recruitment of parents to participate in program

Once staff members have an understanding of the group and its purpose, they will be asked to recommend or refer parents to the group. Staff will be encouraged to refer individuals whom they think would benefit from the group, would be willing to participate and would be able to function in a group setting. The ability to function in a group setting is determined by the parent's capacity to interact with others without becoming verbally or physically aggressive. This process will serve as a pre-screening for group participation.

Methods

Staff members will review their caseload and identify consumers who would benefit from the program, are willing to participate and would be able to function in a group setting.

Technique

The program will be explained to the residents and they will be encouraged to participate in the program.

Procedure

Participating parents will be oriented to the program then provided with a handout that provides a brief overview of the program.

Materials

Handout to be given to selected parents referred to the program. The handout will be given to the parents after the program has been verbally explained to them. The handout is meant to be a useful tool to aid parents in recalling the details of the program (See Appendix D for a copy of the handout)

Equipment

No specific equipment is needed for this phase of the program.

Facilities

The meetings with the parents will occur in their apartments during their regularly scheduled meeting times with their caseworkers.

Incentives

The incentive will be non-monetary. The incentive to refer parents to the parenting group is the staff's desire to help the residents of the Family Center. The staff is very committed to the work they do seem to be open to new ways to help the residents.

Personnel

Table 18
Component II Personnel

Role	Role Accomplishments	Responsibilities	Relationships
Supervisor	<ul style="list-style-type: none"> - questions of direct service providers answered - assistance in selecting parents to participate in the group provided 	<ul style="list-style-type: none"> - observe on the job performance - coach employees toward strong performance 	<ul style="list-style-type: none"> - with consultant - with staff
Consultant	<ul style="list-style-type: none"> - questions of supervisors and direct service providers answered 	<ul style="list-style-type: none"> - listen to program concerns of client - communicate results of consultation transactions 	<ul style="list-style-type: none"> - with supervisor - with direct service providers - with staff
Non-administrative staff (e.g. case managers, day care workers)	<ul style="list-style-type: none"> - possible program participants identified - possible program participants debriefed on group and given handout - possible program participants referred to implementer of parenting group 	<ul style="list-style-type: none"> - identify parents who may be appropriate for parenting group - discuss parenting group with identified parents - refer parents to the implementer of the parenting group 	<ul style="list-style-type: none"> - with supervisor - with consultant - with direct service provider
Direct Service Providers	<ul style="list-style-type: none"> - receive referrals for parenting group 	<ul style="list-style-type: none"> - receive referrals - conduct parenting group 	<ul style="list-style-type: none"> - With supervisor - With staff - With consultant

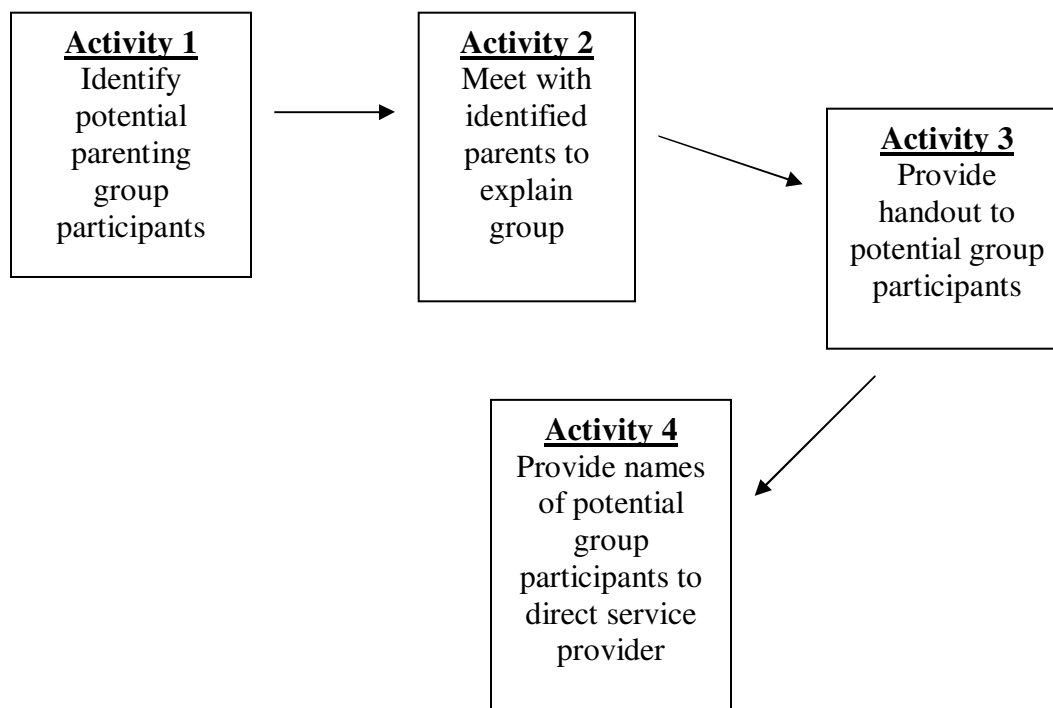
Sequencing of Activities

Figure 2. Sequencing of activities for component II.

Component III: Parenting Group

The parenting group is the portion of the program that addressed the specific goals set forth in the purpose and goals section. The group was both process-oriented and skill based. Each session provided time to explore and process parents concerns about their current parenting issues. There was also an opportunity to discuss the role their mental illness and past relationship with their own caregivers plays in their parenting. The group also contained a skill building and psychoeducation component. Thus, parents learned about attachment and specific skills to help them improve the attachment between themselves and their children.

Methods

Weekly group meetings were held where parents are allowed to explore issues around their own parenting practices and where they will learn new skills.

Technique

Group discussions were facilitated by asking specific questions, listening to responses, noting common themes and encouraging all members to participate.

Procedure

During the first session, the implementer oriented the parents to the group by explaining the purpose and objectives. In this first meeting, co-facilitators worked collaboratively with group members to set ground rules for the group. Each subsequent session involved both process oriented discussions and skill building exercises.

Materials

Parents were given a parenting group workbook that included handouts, in-session activities, and homework assignments. The handbook was used each session as a

supplement to the discussion and as a tool for skill building. There was also a curriculum guide for the group facilitator (See Appendix J for curriculum guide).

Equipment

Equipment needed included folders, paper, pencils and pens, and toys for play therapy activities.

Facilities

The director of the program identified a room that was be used for the parenting group. This room is typically used for all groups provided for consumers at the Family Center.

Incentives

The direct service provider initially selected to co-facilitate the parenting group was already expected to run process and psychoeducation groups for residents of the Family Center as it is part of his job description. However, the incentive to implement this particular group was a non-monetary one related to improving his skills as a group facilitator and learning about attachment related issues and interventions.

The parents' incentive to participate was to improve relations with their children and to improve their skills as parents. The parents were also be provided food during group meetings as a further incentive to participate.

Personnel

Table 19
Component III Personnel

Role	Role Accomplishments	Responsibilities	Relationships
Administrator	- facilitated access to necessary resources	- monitor participant progress - complete program reports - assess personnel performance	- with consultant - with supervisor - with direct service provider - with evaluator
Supervisor	- support provided to direct service provider	- observe performance of staff - provide feedback on performance - provide support and counsel for staff	- with consultant - with administrator - with direct service provider - with evaluator
Consultant	- components designed - materials selected and obtained - evaluation plan completed	- provide program design troubleshooting when needed - design program components - select and obtain materials - design evaluation plan - train direct service provider	- with administrator - with supervisor - with direct service provider - with evaluator
Direct Service Provider	- Program implemented - Lessons taught	- facilitate parenting group - teach lessons - provide safe space for program participants to discuss difficult topics	- with supervisor - with consultant - with administrator - with evaluator
Evaluator	- program evaluated	- implement evaluation plan	- with consultant - with supervisor - with administrator - with direct service provider

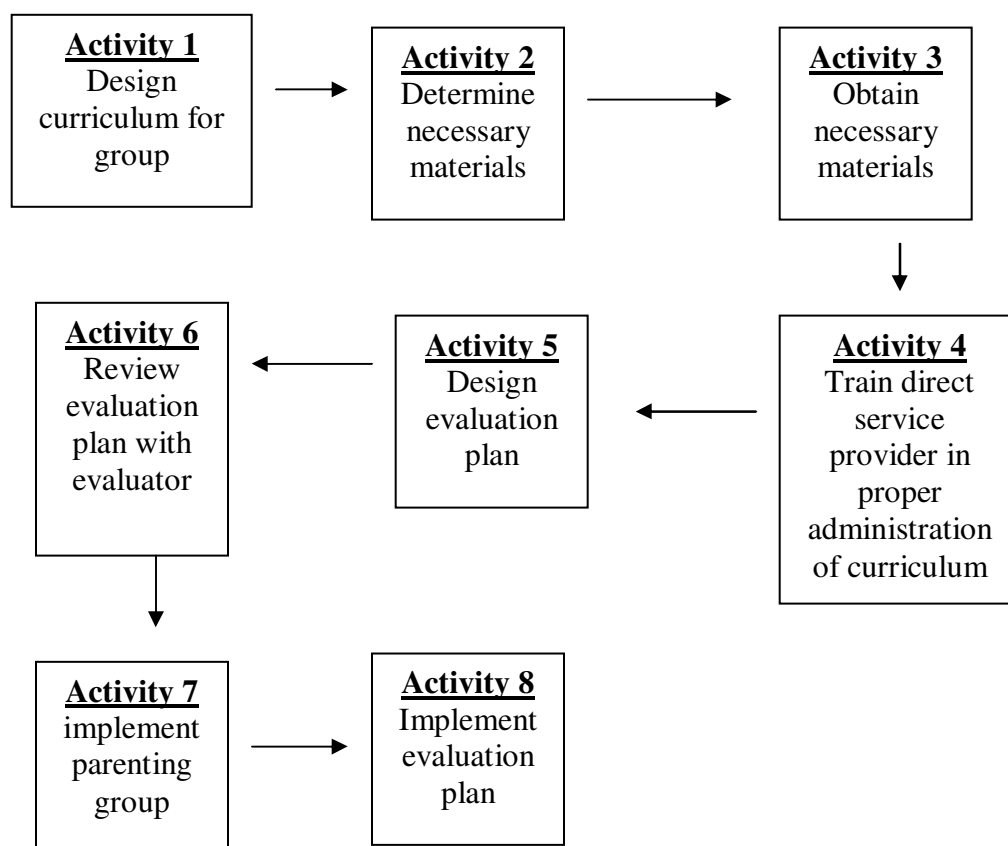
Sequencing of Activities

Figure 3. Sequencing of activities for component III.

Budget

Below is a budget for the cost of clarification, program design and implementation. Certain line items are estimated at a cost of \$0 because the cost is fully covered under the operating budget for the organization where the program is taking place. The salary is listed as a cost of \$0 because the program was designed, implemented and evaluated by the consultant who is a graduate student at Rutgers University. The program design, implementation and evaluation are a part of the consultant's dissertation research and as such she performed these services for free.

Table 20
Program Budget

Resources	Estimated Costs	Funded By
Salaries		
- Program Designer/Implementer/Evaluator	\$0	N/A
Printing & Reproduction		
- Photocopies of worksheets & Forms	\$0	Organization
- Computer Printing	\$75	Consultant/Program Implementer
Office Supplies	\$10	Organization & Consultant/Program Implementer
Equipment Expenses	\$0	Organization
Supplies for Group Sessions		
- Folders for parent workbook (quantity 8)	\$20	Consultant/Program Implementer
- Labels for parent workbook	\$5	Consultant/Program Implementer
- toys	\$50	Consultant/Program Implementer
Incentives – Food, candy	\$50	Organization & Consultant/Program Implementer
Travel	\$104	Consultant/Implementer
Other miscellaneous costs		
- Program completion certificate paper	\$6	Consultant/Implementer
Total	\$320	

Program Evaluation Plan

In order to determine whether the program was implemented properly and resulted in some form of change in the target population, an evaluation was conducted. Three questions were considered in order to assess the program. These questions were: Who participated in the program? How was the program implemented with respect to participants? What appears to be the benefit of the program to participants? The program evaluation results will be reviewed in detail in a later chapter.

Protocol I

Program Evaluation Question 1: Who participated in the program?

The answer to this question determined whether or not participants in the program were the same as or similar to the target population and met designated eligibility criteria.

Data Collection Variables

- participants in program met eligibility criteria

Methods, Instruments, Procedures for Data Collection

The process for determining if program participants met eligibility criteria required multiple methods including permanent product review and interviews with key individuals. There are currently 6 eligibility criteria. See Table 21 below for a review of methods, instruments, and procedures.

Table 21
Overview of Methods, Instruments, and Procedures – Evaluation Protocol 1

Eligibility criteria	Methods	Instruments	Procedures
Is classified as severely and persistently mentally ill	Permanent Product Review	None	Review participants case file to determine his/her classification
Has already been reunified with their child(ren)	Administration of a survey	Initial Parent Survey (<i>see Appendix E for copy of survey</i>)	Include question on the initial parent survey re: the length of time parents have been reunified with their children
Has been referred by their case manager	Permanent Product Review	Referral list Attendance list for each group session	Review referral list, which will be created once referrals from case managers have been submitted. The referral list will be compared to the attendance list for the group.
Has participated in the program's orientation session	Permanent Product Review	Attendance List	Review attendance list for orientation session
Possesses a documented need in agreement with the determined needs of the target population	Administration of a survey	Initial Parent Survey	Responses to the initial parent survey will indicate certain areas of need that should correlate with the determined needs of the target population
Is in their own individual psychotherapy and attends regularly	Interview with key individuals	None	Ask prospective participants during the orientation session whether or not they are currently attending therapy

Methods and Procedures for Data Analysis and Interpretation

The individual designated as program evaluator was responsible for managing the data collected and analyzing it. The initial parent survey was administered and responses were reviewed to determine if the individual met eligibility criteria. The responses were compared to the data included in the needs assessment report to determine if program participants possessed a documented need in agreement with the determined needs of the target population.

Guidelines for Communicating Evaluation Results

The results of the evaluation were communicated to the client as well as to other key administrators involved in the program planning process (see client description for a complete list of key stakeholders).

Protocol II

Program Evaluation Question 2: How was the program implemented with respect to participants?

The answer to this question determined if the program was implemented as planned.

Data Collection Variables

- the program's eligibility criteria are used
- program follows the designated policy and procedures
- the designated methods, techniques, materials and facilities are used
- the phases occur in the planned order
- program implemented within designated budget constraints
- personnel perform assigned roles

Methods, Instruments, Procedures for Data Collection

The process involved in answering this particular evaluation question required multiple methods including permanent product review, questionnaires and direct observation. See Table 22 below for a review of methods, instruments, and procedures.

Table 22

Overview of Methods, Instruments, and Procedures – Evaluation Protocol II

Variables	Methods	Instruments	Procedures
Program's eligibility criteria are used	Administration of checklist	Program implementation checklist (<i>see Appendix F for a copy of the instrument</i>)	Designated staff will complete this checklist to indicate if eligibility criteria have been met
Program follows the designated policy and procedures	Administration of checklist; Questionnaire	Program implementation checklist; Staff Reaction Survey (<i>see Appendix G for a copy of instrument</i>)	Designated staff completed this checklist. Staff will also complete a reaction survey to gather more information about their participation in the process and their feelings about how well it was implemented
Designated methods, techniques, materials and facilities are used	Administration of checklist, Questionnaire	Program implementation checklist; Staff reaction survey	Designated staff will completed checklist. Staff will also complete a reaction survey to gather more information about their participation in the process and their feelings about how well it was implemented
Program phases occurred in planned order	Administration of checklist and questionnaire, permanent product review	Program implementation checklist, Staff reaction survey	Checklist and survey completed. Program evaluator reviewed any other records kept regarding the program to determine if the phases occurred in the planned order.
Program implemented within designated budget constraints	Permanent Product Review		Program evaluator reviewed any financial documents related to the implementation of the program
Personnel performed assigned roles	Questionnaire, direct observation	Staff reaction survey	Program evaluator administered staff reaction survey and also observed the implementation process to determine if designated personnel have completed their assigned tasks.

Methods and Procedures for Data Analysis and Interpretation

The program evaluator collected all completed staff reaction surveys and program implementation checklists. The checklists were reviewed to determine which activities were completed. The surveys were reviewed and each staff members' response was categorized by question. The evaluator reviewed responses, noting similarities and differences in responses. The evaluator then identified, analyzed and determined themes that emerge from the responses.

Guidelines for Communicating Evaluation Results

The results of the evaluation were communicated to key administrators involved in the program planning process (see client description for a complete list of key stakeholders).

Protocol III

Evaluation Question 3: What appears to be the benefit of the program to participants?

Data Collection Variables

- program addresses the original SMART goals outlined

Methods, Instruments, Procedures for Data Collection

In order to determine if the SMART goals are achieved, parents were asked to fill out a parent survey during the first session, which helped to establish a baseline level of functioning as well as determine whether or not they possess needs in line with the documented needs of the target population. The parents completed an additional survey at the end of program participation to determine if any changes had been made. Achievement of goals was also assessed through other methods, including permanent product review, and direct observation. See table 23 for a review of the methods, instruments and procedures.

Table 23
Overview of Methods, Instruments and Procedures- Evaluation Protocol III

SMART Goals	Methods	Instruments	Procedures
Parents able to identify and articulate the parenting practices of their own caregivers and any ways in which these practices have influenced the way they parent their own children.	Direct observation, review of participant workbook; Interview	Participant workbook (<i>see appendix J for copy of curriculum</i>); Group Leader Interview (<i>see Appendix I for copy of instrument</i>)	Direct service provider noted when participants are able to do this during group sessions. Direct service provider reviewed participants' workbooks. Evaluator interviewed direct service provider
By the end of the 12 week program participation period, parents will be able to clearly state at least one way in which their mental illness impacts their parenting abilities	Direct observation, review of participant workbook, Interview	Participant workbook; Group Leader Interview	Direct service provider noted when participants were able to do this during group sessions. Direct service provider reviewed participants' workbooks. Evaluator interviewed direct service provider
Parents will be able to identify ways in which they are able to connect emotionally with their children and ways they are not able to do so.	Direct observation, review of participant workbook, Interview	Participant workbook; Group Leader Interview	Direct service provider noted when participants were able to do this during group sessions. Direct service provider reviewed participants' workbooks. Evaluator interviewed direct service provider
Parents will be able to identify and articulate at least one step they can take in improving their emotional connection with their children	Direct observation, review of participant workbook	Participant workbook; Group Leader Interview	Direct service provider noted when participants were able to do this during group sessions. Direct service provider reviewed participants' workbooks
Parents will be able to articulate at least one reason why it is important to engage in play with their children	Direct observation, review of participant workbook; Interview	Participant workbook; Staff interview	Direct service provider noted when participants are able to do this during group sessions. Direct service provider reviewed participants' workbooks
Parents will be able to identify at least one play activity that they will engage in with their children by the end of the 12 week program period	Direct observation; Questionnaire	Initial and Follow up Parent surveys (<i>see Appendix H for follow up parent survey</i>)	Direct service provider noted when parents were able to identify a play activity during group sessions. Reviewed responses to parent survey
Parents will increase the amount of time they play with their children by 10% by the end of the program period.	Questionnaire	Initial and Follow up Parent surveys	Review of responses to parent survey

Methods and Procedures for Data Analysis and Interpretation

Program evaluator collected surveys completed pre- and post- group. Evaluator compared individual participant's responses on the pre- and post- group surveys to determine if any change has occurred. Program evaluator interviewed direct service provider to discuss participants' responses during the group sessions.

Guidelines for communicating evaluation results

The results of the evaluation were communicated to the client as well as to other key administrators involved in the program planning process (see client description for a complete list of key stakeholders).

Summary

In this program design phase, information gathered during the clarification phase was used to inform the various elements of the program design, which includes the goals, purpose, eligibility criteria, methods, materials, equipment, facilities, components, budget, personnel, and the program evaluation plan. This program design document was used to create the Attachment Based Parenting Program. The goals and purpose of the program was to provide parents with psychoeducation about attachment and bonding with their children, to teach them skills to improve their relationship with their children and to provide an opportunity to explore and understand ways their own psychological functioning impact their child rearing practices. The Attachment Based Parenting Program was designed to take place over 12 weeks at a supportive housing residence that provides services for parents with a history of mental illness.

CHAPTER VI

DESCRIPTION OF PROGRAM IMPLEMENTATION

Abstract

This chapter will delineate the implementation of the Attachment Based Parenting Program. The program design included three components which were (1) orientation of staff to the program, (2) recruitment of participants, and (3) the parenting group. The parenting group was conducted over the course of 12 weeks from September- December 2008. The implementation of each component will be described. The description of the component 3 – the parenting group- includes explication about the process of identifying a co-facilitator, a description of the development of the group curriculum and finally a discussion of each group session. Challenges to group implementation are also highlighted.

INTRODUCTION

The program design involved three phases or components, which included the orientation of staff to the parenting program, the recruitment of participants, and the parenting group. The orientation of staff served to ensure that staff members understood the purposes and goals of the group, and thus aid them in making appropriate referrals to the group. Once possible group members were identified, outreach was made to inform them of the group and to engage them in participation. The group was then facilitated by myself and at times a staff member. The group was conducted for 12 weeks and provided an opportunity for the participants to learn new skills, to process their

experiences as parents and to provide support for one another. The implementation of each component will be described fully in this chapter.

Orientation of Staff to Parenting Group

As staff would be responsible for referring participants to the parenting group, it was important for them to have a full understanding of the goal and purposes of the group. To facilitate this understanding, I attended a regularly scheduled staff meeting to present the parenting group to staff. The presentation involved a brief description of the group as well as a handout with an overview of the group for each staff member to retain. During the staff meeting I addressed questions regarding the focus of the group and the frequency.

Recruitment of Participants

The staff meeting also served an opportunity to identify potential group members. The director and staff reviewed a list of residents to identify possible participants. The staff noted that all residents could benefit from such a group, but that there was a small subset of residents who tended to create problems when in group settings. The staff identified these individuals and stated that they would not be asked to join the group. The staff then identified a list of individuals that would be a good fit for the group. The original plan was for case managers to discuss the group with participants individually and encourage them to participate. However, this did not occur. The staff identified possible participants during the staff meeting and I then followed up with the parents once the group was ready to begin.

Several weeks prior to the start of the group I posted fliers throughout the residence to alert consumers of the group. I also held an orientation meeting a week

before the start of the group. Staff members sought out previously identified parents and informed them of the orientation meeting. Six parents attended this meeting. During the meeting, I introduced myself and explained my role at the residence. I explained the purpose of the group and discussed with parents their feelings about participating in the group. Some of the parents reported that they had already participated in a number of parenting groups and were not sure if they were interested in attending. Other parents stated that they could benefit from participation in such a group. I discussed with parents what topics they were interested in learning about during the group.

Common concerns noted during the orientation meeting were issues around discipline and structure. Several parents mentioned a concern that many parenting groups at the Family Center were geared towards parents with younger children. One parent noted her continued frustration with this and stated that she did not wish to participate if the group did not also address the needs of parents with older children/teenagers. I noted her concerns and informed the parent that this would be taken in consideration as the ages of children in the families would be factored into the group discussions and interventions. To that end, I asked each parent the age of their children so that I could take into account the developmental level of their children when teaching the parenting skills. Many of the parents had children between the ages of 2 and 10 years old; however, there were a few parents with children who were adolescents. At the end of this orientation meeting, I provided parents with a schedule of the parenting group sessions.

Parenting Group

The final component of the program design was the parenting group. There were several steps involved in this component including designing and developing the materials (i.e. group curriculum and parenting workbook) for the group, identifying a staff member to co-facilitate the group, and finally conducting the group sessions. The parenting group was conducted over 12 sessions and included opportunities for parents to process their own experiences and feelings particularly feelings about their own histories and the impact of separation from their children. The following sessions then focused on psychoeducation and specific activities designed to help them begin the process of improving their relationship with their children (see table 24 for an outline of group sessions).

Table 24
Outline of Parenting Group Sessions

Session number	Title
Session 1	Introduction
Session 2	Identifying your current strengths and weaknesses as a parent
Session 3	Separation and Reunification
Session 4	Processing your own parenting history
Session 5-7	Perspective taking: understanding your child's emotions
Session 8 &9	Play and the parent/child relationship
Session 10	Discipline skills: overview
Session 11	Discipline skills: setting limits and managing your anger
Session 12	Wrap up

Finding a co-facilitator

It was determined over the course of the dissertation project that I would co-facilitate the parenting group with a staff member from the residence. All parties involved felt that co-facilitating the group with a staff member would be beneficial for a number of reasons. Having a member of the staff, who is familiar with the residents, present for the group sessions would ideally help the participants feel more comfortable in the group. In addition, I determined that in order for the program to be replicated at this site and to become institutionalized, it was important to have a staff member involved in the process of running the group.

At the outset, a staff member was identified that would aid in the facilitation of the group. This person was selected because he was, at the time, actively involved in the planning and facilitation of other groups provided at the residence. In addition, this staff member had worked at the facility for a number of years and was very familiar with each resident as well as the particular challenges of working with this population. However, over the course of the program planning phase, this staff member's role changed within the organization and he was no longer responsible for running groups. A new staff member was hired who was meant to oversee the clinical services provided to the residents at the facility. It was determined by the client, that this new staff member would co-facilitate the group.

Once this decision was made, I began to consult with the new staff member and solicited feedback about the group curriculum. I provided the new co-facilitator with materials I intended to use for the group. The staff member and I frequently

communicated via email as she was often unavailable to meet face to face due to the many demands on her time. The staff member attended several of the initial group sessions and assisted in facilitation. However, as the group progressed, she was often unable to attend due to other demands and crises that often occurred at the residence.

Group Curriculum

The group curriculum is largely based on attachment literature, which served to inform my understanding of parent-child relationships and attachment; in particular the ways in which separation, particularly in foster care, can affect said relationship (see Appendix J for copy of group curriculum). Several of the activities and handouts used in the curriculum were drawn from other attachment interventions and measures, which will be described in the following sections of this chapter.

Adult Attachment Interview

During the twelve week parenting group, two of the sessions focused on discussions about the participants own experiences with their caregivers. Many of the discussion questions were generated from the Adult Attachment Interview, which is a semi-structured interview designed to assess attachment styles in adults (Heese, 1999). The interview protocol, developed by Main & Goldwyn consists of 18 questions with the entirety of the interview transcribed verbatim (Heese, 1999). A variety of tasks are included in the protocol; subjects are asked to provide a general description of their relationship to their parents in childhood and then to generate five adjectives that describe these relationships (Heese, 1999). The subject is then asked what he or she did when emotionally upset, physically hurt or ill and how their parents responded (Heese, 1999). There are also questions about major separations, possible experiences of rejection,

discipline and experiences of abuse (Heese, 1999). Given this, the questions that comprise the Adult Attachment Interview were quite appropriate for the focus of these particular sessions of the parenting group.

Circle of security project

As stated previously, interventions and materials were drawn from several other attachment programs. One such program is the Circle of Security project. The primary ingredients for change in this program are the relationship between the therapist and the parent, affect regulation and reflective functioning. The authors posit, as do many other attachment researchers, that children learn to manage their affect through their parents. Therefore, the intervention works to help parents learn to manage their affect, particularly when strong feelings arise around their own history of insecure attachment and emotional deprivation. A major goal of the group is to provide a safe space that acts as a holding environment for these strong emotions that have chronically interfered with their ability to respond to their child's needs (Powell, Cooper, Hoffman & Marvin, 2007).

Thus, the Circle of Security Project attempts to take into account parents' own attachment issues and history of emotional deprivation and how these may affect the attachment bond between them and their children (Powell et al., 2007). This, as noted previously, is one of the primary focuses of the current parenting group. The Circle of Security project informed the specific areas I chose to focus on in the group sessions and also provided several activities done with the parents.

The Compassion Workshop

The compassion workshop was developed for spouse, child and elder abusers to address what the author's describe as "attachment abuse". Attachment abuse is defined as "that which impairs, subverts, distorts, or damages the self-building nature of attachment interaction" (Stosny, 1995, p.4). The group employed a didactic and process oriented format to help group members explore their own history of abuse and ways in which they can learn to have compassion for themselves as well as their victims. The key targets for intervention in the Compassion Workshop are "... deficits in perspective taking, sympathy for self and loved ones, validation of the emotional experience of loved ones or emotional vocabulary" (Stosny, 1995, p.91). Each of these issues was relevant to the parenting group and was something I hoped to address. The information gathered from this attachment program helped inform my thinking about the parenting group. In addition, I used certain group activities and handouts from the Compassion Workshop in my curriculum.

Parent- Child Interaction Therapy

Parent-Child Interaction Therapy is an intervention based on the attachment literature. There are two phases of this intervention (child-directed interaction phase and parent-directed interaction phase) that provide opportunities for parents to learn how to play with their children as well as teach useful discipline skills.

The child-directed interaction phase (also known as the relationship enhancement phase) is intended to create or strengthen a positive, mutually rewarding relationship between child and caregiver. PCIT attempts to improve parent-child relationships through teaching parents the fundamental relationship-building techniques used by play

therapists. These techniques are taught during the child-directed interaction phase and include describing what a child is doing; reflecting appropriate speech and feelings, and praising appropriate behaviors. These skills often generalize to situations outside of the special play time parents are instructed to implement and result in a decrease in family stress (Johnson, Franklin, Hall & Prieto, 2000).

During the parent-directed interaction phase parents are taught appropriate discipline practices including establishing the four preconditions for discipline; these include making sure the child knows exactly what they are supposed to do (or not do), establishing the consequences for misbehavior, ensuring that the child is developmentally capable of doing what he/she is being asked to do, and making sure that the parents' own frustration and anger were under control before carrying out discipline (Johnson et al, 2000).

The PCIT model provided useful tools that could be taught to parents to begin to increase positive interactions between themselves and their children and thus foster attachment. In addition, as the needs assessment results revealed that parents at the residence could use considerable assistance in learning appropriate discipline techniques, the tools included in the PCIT model were quite helpful. The parenting groups sessions that focused on play and the parent/child relationship, used the tools from PCIT almost exclusively. In addition, several of the PCIT handouts about discipline and many of the skills taught in the parent-directed phase were used in the discipline skills sessions of the parenting group.

Group Sessions

The group occurred over 12 weeks during the Fall/Winter of 2008. Each group session was one hour long. Despite the parents' attendance at the orientation meeting, they often required frequent reminders to attend regularly scheduled groups. After consultation with facility staff, I developed a routine each week of knocking on each resident's apartment door prior to the start of each group session to remind them of the scheduled meeting. This method had varying degrees of success as many participants had sporadic attendance at group sessions. However, there were some participants who attended almost every group session. There was one group session on November 11, 2008 that no one attended. As a result, the group met for only 11 out of the 12 scheduled sessions.

As an incentive for attendance, I provided snacks at each group session. In addition, parents were informed in the first session that they would receive a certificate upon completion of the group. In addition, I created a parent handbook for each participant that included all handouts provided throughout the group as well as copies of the parents' responses to various questionnaires and written activities done throughout the group. Parents received these handbooks at the final group session.

Session 1

The objective of the first session was to provide parents with an overview of the group, to establish rapport and to develop an understanding of the parents' areas of strength and weakness. The agenda for the session was to (1) a welcome to group members and reintroduction, (2) introduction of parents, (3) Explanation of the purpose of the group, (4) Establishment of group rules, (5) completion of parent survey, and (6)

beginning discussion about separation from their children. Four parents attended the first group session.

I found at the end of the first group that my agenda was quite ambitious and that I needed to decrease the level of expectation about how much could be accomplished in each group session.

I began the session by welcoming the parents and reintroducing myself as there were parents present who had not attended the orientation meeting the week before. I then asked each parent to introduce themselves and to briefly explain why they were interested in attending the parenting group. While I expected this portion of the session to be brief, each parent went into detail about their current struggles and described what stage of the reunification process they were in. One parent reported that she is currently separated from her children and does not see them often. She explained that her children had been in foster care for a number of years. This parent was able share her feelings about being separated from her children for such a long period of time and how it affected her to see them growing older and going through major transitions (e.g. starting high school) without her. She stated that what she hoped to get out of the group was to improve her parenting skills overall.

Another mother also stated that her children were still in foster care and that she was currently mandated to complete parenting classes. She was curious to know if the current group would meet the demands of the court. I informed her that it would not likely meet the mandate by the court. Despite this, she was willing to continue participation in the group.

The third mother stated that she was recently reunited with her children and is happy to have them back. However, she stated that she was struggling somewhat with the transition to being a full time mother again. She stated that she hoped to get some support around this issue in the group. The last parent talked in depth about her background and her own history in foster care. She also discussed her young son and stated that she felt they had a close relationship.

Following the introductions I explained the purpose of the group, the topics we would cover, and the different activities that we would do together. I also reminded them of the time and frequency of meetings and provided each participant with a group of the schedule. After this, I moved in to discussing the group rules. I asked the parents' to identify rules that they felt were important for the group. However, only one parent contributed stating that group members should agree to not "talk out of turn", to agree "not to put each other down", and "what's said in here stays in here." I agreed with these rules and asked if other parents did as well. The other parents indicated that they agreed. I also added the rule that parents should "avoid putting yourself down" and that parents were only allowed to miss three of the twelve group sessions. The parents agreed to the additional rules.

After reviewing the group rules, I provided parents with the initial parent survey, which was intended to provide me with an understanding of the parents' strengths and weaknesses. This survey was created as a part of the evaluation plan and was intended to help track the parents' progress over the course of the group. As such, I did not intend for the survey to be used to generate discussion. However, after completing the survey, one of the parents inquired about the possibility of discussing the questions in the survey

as she felt that they were “good questions that really made me think.” I asked the other parents if they were interested in discussing the survey and they agreed. Unfortunately, we had run out of time during the first session, so I agreed that we would discuss the survey the following week (see appendix for all handouts provided).

Session 2

The objective of the group was to begin to process some of the parents’ concerns about their own parenting abilities and to discuss the impact separation and reunification had on their relationships with their children. The agenda for session two included: (1) group check in, (2) Review of parent questionnaire, (3) Begin discussion regarding separation and reunification.

This group session began late as the members had forgotten about the group. I was able to locate one of the members of the group outside of the residence. She attended the session and brought several of her friends from the residence who had not participated in the previous session. One of the people she invited to attend the group was an individual who was previously singled out by the staff during the staff orientation as a “problematic” resident who would not be a good addition to the group. Despite this, I was unable to identify an appropriate method to discourage his attendance, so I allowed him to attend the group. There were five parents in attendance for session 2.

As there were new members present, I briefly explained the purpose of the group and encouraged participants to introduce themselves. I also briefly reviewed the group rules. The intent of the group was to discuss the questionnaire that was completed during the previous session. I provided the new members with a copy of the questionnaire and asked them to complete it. As some of the members completed the questionnaire the

previous week, they engaged in conversation while they waited for the new members to finish. As a result, it was somewhat difficult to regain the participants' attention when it was time to discuss the questionnaire.

The co-facilitator and I then began the discussion of the questionnaire. The parents were able to identify specific parenting issues they struggled with. For instance, one parent noted that she is concerned that her children frequently lie, while another parent noted that her son does not follow directions when in public. The parents were able to provide support and feedback to one another about these areas of difficulty. However, there was one particular parent who tended to dominate the discussion, which appeared to make some parents visibly uncomfortable. One parent even left the group early as a result. When speaking with the co-facilitator following the group, she noted that this particular parent who dominated the conversation has difficulties with several of the other residents. It is for this reason that the staff previously identified him as "problematic" and did not feel that it was appropriate for him to participate in the group. The co-facilitator noted that she would address the issue with this parent separately.

Session 3

The objective of session three was to begin to process with parents their feelings about the separation from their children and ways in which they have handled the reunification process. The agenda for session three included: (1) group check in and (2) discussion questions about the separation and reunification process. Five parents attended this session.

Discussion questions for this group session included:

1. How long were you separated from your children?

2. Who were your children with? What steps did you take to get your children back?
3. What did you imagine it would be like to get your children back?
4. How did you feel while going through the process of getting your kids back?
5. What was it like once you had your children back?
6. What have some of the challenges been to having your children back?
7. What are some of the good things that have come out of having your children back?

This topic was particularly difficult for the parents to discuss, but they were very open and reflective about the process and provided support for each other when needed. There was only one member who did not participate in the discussion, but she listened intently throughout the session.

Several of the parents discussed the reasons for the removal of their children. Many of the parents in the group stated that their children were removed for a variety of reasons. One mother reported that her family removed her children from her care due to domestic violence in the home; other parents noted that they lost custody of their children due to their mental illness. We discussed as a group the reunification process and how difficult it was. One mother reported that when her youngest child was returned to her, he was not even aware that she was his mother. Another parent discussed her ambivalence about being a mother and her struggles with connecting with her son now that he is living with her full time. She expressed that she often has difficulty showing him affection and is not sure that she wants to be a full time parent to him. Other members of the group were able to empathize with her situation and provided support for her. I commended her for her honesty and empathized with her feelings of ambivalence. The co-facilitator discussed with this mother the importance of providing her son with affection. I noted to the group that we would discuss that particular issue in more detail and begin to learn new skills to establish a connection with their children.

Session 4

The objective for this session was to process the parents' own histories with their caregivers and ways in which these histories impact their current relationship with their children. The agenda for this meeting included: (1) Group Check in and (2) Discussion questions. Three parents attended this session.

During the group check in, one of the members stated that the previous week's discussion brought up many difficult things for her and made her feel depressed. We processed this issue as a group and the co-facilitators discussed with the group ways in which they can manage some of the negative affect that may come up as a result of our discussions.

I then introduced the topic for discussion for the current session. The discussion questions used were taken from the Adult Attachment Interview. A sample of the questions is listed below:

1. What was your relationship like with your parents/caregivers as a young child?
2. When you were upset as a child, what would you do?
3. Did you ever feel rejected as a young child?
4. In general, how do you think your overall experiences with your parents have affected your adult personality?
5. Why do you think your parents behaved as they did during your childhood?
6. How do you respond now, in terms of feelings, when you separate from your child/children?
7. If you had three wishes for your child twenty years from now, what would they be? Is there any particular thing which you feel you learned above all from your own childhood experiences? I'd like to end by asking you what would you hope your child might have learned from his/her experiences of being parented by you? (Main, 1984)

Members were forthcoming with stories from their own childhoods. For instance, when asked the first discussion question, one parent reported that her mother would often say hurtful and demeaning things to her that negatively affected her self-esteem. Another

parent shared stories of her mother's substance abuse and the impact it had on her. She reported that as the oldest child she often served as the parent of the household, maintaining order and aiding her siblings; in addition, she eventually began abusing substances herself and would at times use drugs with her mother.

The group leaders also encouraged the members to think about ways in which their upbringing has impacted their adult functioning and their roles as parents. Overall, the group members were very self-reflective and able to make connections about their past history and current functioning. For instance, one parent, who is mentioned above, was able to reflect on ways in which she "made the same mistakes my mother did" as she was not fully present for much of her parenting duties due to substance abuse. Another parent was able to reflect that she rarely shows her son physical affection because she did not know how. She was able to recognize that she had never received much affection in her own childhood and was often uncomfortable providing this affection for her child. The third parent noted that her experiences as a child affected her self-esteem and contributed considerably to her depression. She stated that she worked very hard to ensure that her children would not have the same experience during their childhood. She also stated that she actively works to have open communication with her children and always want to have a bond with them. When asked what their three wishes were for their children they all stated that they hoped their children would be happy and successful.

Session 5

The objective of session 5 was to begin to teach parents how to take the perspective of their children. The goal was to begin to help parents understand their children's emotional experience. The agenda for the group included: (1) group check in, (2) perspective taking activities, (3) Discussion, (4) homework assignment. Seven parents attended this session.

I began the group by checking in with members to gather their reactions about the previous session and any areas of concern they wished to address. The parents all indicated that they did not have anything they wished to discuss. I then introduced the first activity, which was adapted from an activity from the Circle of Security project. I provided each parent with a piece of paper and asked them to write a description of one of their children. Once the parents completed the task, I asked for volunteers to share their descriptions. A few of the parents volunteered descriptions of their children.

I then asked if anyone was willing to give a real life example that fit the description of their child. For instance, one parent used these words to describe her son: "good, sweet, bad, eats too much." When I asked for an example, she stated that her son eats constantly, even at times when he is not hungry. My goal was to help the parents begin to understand the motivation for their children's behavior and to take their children's perspective. In order to accomplish this, I asked the mother several follow up questions such as, "what do you think makes him behave this way? In your example what was he thinking and feeling? What were you thinking and feeling?" During this process, the mother was able to reflect on the situation and came to the conclusion that

her son likely consumed so much food because he was neglected in his previous foster care placement and did not receive enough nourishment.

The next activity required the parents to complete a questionnaire about their most recent argument with their child. The questionnaire asked them to think of a recent disagreement with their child and to then answer a series of questions. This activity was taken from the Compassion Workshop previously described. Below are the questions parents were to answer:

1. What was he or she thinking?
2. What was he or she feeling?
3. Did your child feel that you understood him or her?
4. How would (s)he describe you at that moment (what did your behavior seem like to her or him?)
5. Did you feel understood by your child?
6. What might you have done to make yourself better understood?

This activity had varying degrees of success. Several parents were unable to identify an argument with their child because as one parent noted “my children aren’t allowed to argue with me.” A few of the parents were able to identify an argument with their child and completed the questionnaire. However, only one of the parents was willing to share the nature of the argument. During the discussion she was able to identify her child’s thoughts and feelings and to discuss ways in which her child’s feelings impacted her as a parent.

Overall the activities during this session produced mixed results as some parents were able to generate examples and to attempt to take their child’s perspective while other parents were not. I originally attended to provide the parents with a homework assignment for the week, but there was not enough time. The parents received the homework assignment in a later session.

Session 6

The objective of this session was to continue working with parents around understanding their children's feelings. The agenda included: (1) group check in, (2) follow up regarding Our Most Recent Argument activity, (3) discussion questions, (4) homework assignment from previous week's session. Only one parent attended this session.

As a result, I was not able to cover the intended material. Rather than follow my agenda, I asked the parent in attendance if there were any particular issues that she wished to discuss. The parent discussed her recent court visits and the long journey to retain custody of her children. We discussed further the reasons that her children were initially removed from her care. The mother discussed her ongoing struggles with mental illness and revealed that she has lost custody of her children on more than one occasion due to decompensation in her functioning. We discussed ways in which she can improve her functioning and the feelings of sadness and loss she struggles with due to limited contact with her children.

Session 7

I arrived at the residence on the date of this session and found that none of the regular group participants were present for the scheduled meeting. This particular group session happened to fall on Veteran's Day and it appears that group members took the opportunity to leave the residence and spend the day with their children who were out of school. Therefore, no group was held on this day.

Session 8

The objective of this group was to continue working with parents around perspective taking. The agenda for this group included: (1) Group Check in, (2) Discussion questions about understanding their children's behavior, (3) Discussion questions about dealing with their children's emotions, (4) Review Kids and Stress handout, (5) Homework assignment. Six parents attended this group session.

It was clear at the beginning of the group that there was tension between group members. This resulted in one member disengaging during the session. I tried on several occasions to engage this parent in group discussions, but had very little success.

After the group check in, we began with questions meant to generate discussion about motivations for their children's behavior. The discussion questions are listed below:

1. Overall do you feel that you understand your children's behavior and why they do the things they do?
2. Can you give an example of a situation where you understood them?
3. In that situation what were they thinking/feeling?

Most of the parents were actively engaged in the discussion and felt that they understood their children's behavior and feelings. One parent described her oldest son's current behavior problems stating that he has been getting in trouble at school and stealing. She reports that she is still separated from her child. She described her son's feelings of sadness and abandonment due to their separation and believes that these feelings are driving his behavior.

We then moved in to the next set of discussion questions about dealing with their children's emotions. The discussion questions are listed below:

1. Do you talk to your children about feelings? If so, what are those conversations like? If not why not?

2. What types of things have you noticed make your children upset? When they are upset what do you do?

The first question generated a considerable amount of discussion as all group members noted that they talk to their children about feelings. Each member provided an example of a discussion they have had with their children about feelings. We then reviewed a handout entitled “Kids and Stress: Understanding your child’s emotions”, which was taken from the PCIT manual. The handout provides examples of various stressful family situations as well as a child’s responses to stress. The handout highlights the differences between the ways in which adults and children handle stress and provided tips for parents on how to address their children’s distress. The handout contained useful information, but was somewhat long and did not hold the member’s attention for an extended period of time.

I concluded the group by providing parents with a homework assignment. The group members were given an assignment to engage in a 5 minute conversation with their children about an event in the child’s day that made them feel, happy, sad, or mad, and to write down a few words about what the experience was like for them.

Session 9

The objective of this session was to introduce the importance of play and to begin to teach parents play therapy skills based on the PCIT model. The agenda for this session was as follows: (1) group check in and review of homework assignment, (2) introduce the rationale for playing with your child, (3) brief discussion, (4) describe the idea of “special play time”, (5) Review the do’s and don’ts of “special play time”, (6) role play skills. Five parents attended this session.

At the start of the session we reviewed the homework assignment from the previous session. Unfortunately, while the parents' seemed initially receptive to the idea, none of them followed through with the homework assignment. When a group discussion was raised about reasons for this, most parents replied that they "forgot" or "didn't have time". The group leader attempted to explore the issue further but was met with resistance. The group leader encouraged the parents to attempt the homework assignment when they felt ready to do so.

Following the discussion of the homework, I introduced the focus of the current session and provided the rationale for engaging in play with their children. I presented the rationale as follows: "Over the next few weeks we will learn a specific way to play with children that helps them express their emotions and improve the bond between the two of you. The type of play we will discuss is what is typically called play therapy." The parents and the facilitators then had a discussion about play. The discussion questions used are presented below:

1. Do you play with your children?
2. What types of things do you do when you play?
3. What is it like to when you play with your kids?
4. How do you think your children feel when you play together?
5. How do you feel when you play with your children?

Several members noted that they do play with their children and discussed the various types of activities they engage in. However, some of the parents stated that they do not play with their children. One mother stated that she does not play with her sons because that's not how I am...I don't see the point of playing with them, but if there is let me know." We discussed as a group any feelings of discomfort that might arise during play with their children. I then introduced the idea of special play time with their children.

I explained to the parents that we would learn new skills today that could be used during special play time with their children. Parents were encouraged to set aside five minutes a day to play with their children. During this time, parents would work to describe what a child is doing; reflect appropriate speech and feelings, and praise appropriate behaviors. I also discussed with parents ways in which this can be adapted for older children. The idea of special play time was met with reluctance, so the group had a discussion about the reasons for the reluctance and ways that they can incorporate the idea of special playtime and the ensuing skills, into interactions they already have with their children, which seemed more acceptable to the parents.

We then reviewed the do's and don'ts of the special play time described in table 25 below. Following presentation of the do's and don'ts, I encouraged parents to give examples of each. We then followed this with opportunities to practice. I asked for volunteers to do a role play, but parents were hesitant to engage. As I result, I role played the skills with the co-facilitator.

Table 25
Do's and Don'ts of Special Play Time

Do's	Don'ts
Behavioral description - describing what your child is doing	Avoid commands
Reflection - repeating or paraphrasing what your child says	Avoid questions
Labeled praise - stating specifically what you like about what your child is doing or saying	Avoid critical statements and sarcasm

Once parents observed the role play between the co-facilitators, they were more willing to engage in practicing the skills. Several parents provided examples of play activities and one parent volunteered to practice using the "Do" skills while I played the

role of the child. During the role play, this mother at times would use commands and questions. When I noted this, she became frustrated and replied “I don’t know what to say.” I empathized with her frustration and encouraged her to continue. She had particular difficulty with the labeled praise stating “that’s not verbiage normal for black people.” We discussed as a group ways in which the labeled praise skill felt inauthentic and what words they could use that felt more natural to them.

Session 10

The objective of this session was to continue to discuss and practice the PCIT skills. The agenda for the group was as follows: (1) group check in, (2) review of PCIT do’s and don’ts, (3) role playing. Three parents attended the session.

I began the group by reviewing the PCIT skills taught during the previous session. Two of the parents present did not attend the previous session, so we discussed briefly the types of play activities they do with their children and the importance of play. The parents described activities they engaged in with their children and identified possible opportunities to use the PCIT skills. After discussion the do’s and don’ts in more detail, I asked for volunteers to participate in a role play.

Two of the parents volunteered and took turns playing the role of the parent and the child. During the first role play, the parent portraying a child decided to draw a picture. The other parent was able to use some of the do skills and was particularly good at labeled praise. She struggled, however, with avoiding the use of commands and questions. She responded well to corrections in technique and appeared engaged in the role play.

The parents then switched roles. In this instance, the individual playing the “parent” role had considerable difficulty with the task. Throughout the role play she pretended to wash the dishes and was unable to provide undivided attention to the “child.” She did, however, make some attempts to use labeled praise and behavioral descriptions. We discussed at the conclusion of the role play, her feelings about playing with her children. She reiterated statements made during the previous session about her reluctance to engage in play with her children. I explored with this parent other activities that she does with her children. She replied that she enjoys drawing with her sons. I encouraged her to consider the time she spends drawing with her sons as the “special play time” and to use the PCIT skills during this time. The parent reported that she would attempt to do so.

At the end of the session, one of the parents mentioned that her sons were exhibiting some oppositional behavior at home. She expressed that she is having difficulty managing this behavior and sought advice about the issue. I discussed with the group the importance of setting limits, praising appropriate behavior and ignoring negative behavior. I noted that we would cover discipline techniques in greater detail in the following sessions. The parent also noted during the discussion, that she often becomes very angry when her sons do not follow directions and has difficulty managing this anger. We discussed as a group the importance of managing anger when disciplining the children. I informed them that this was also a topic that would be discussed further in following sessions.

Session 11

The objective of this group session was to provide psychoeducation about discipline skills. The agenda for this session was as follows: (1) group check in, (2) Discussion, (3) Didactic about discipline skills, (4) Role play of skills learned. Only one parent attended this session.

As there was only one parent in attendance, I did not follow the set agenda very closely. However, the parent and I did discuss discipline issues in depth as she reported that she received a call from her son's school earlier in the day due to his misbehavior. She expressed feelings of anger and frustration about her son's continued misbehavior, particularly in the school setting. She also expressed feeling overwhelmed and hopeless as all of her attempts to discipline her sons have had little effect. She reported that she has tried taking away toys from the boys, but that does not lead to improvement in their behavior. She then complained that she could not hit her sons due to her previous involvement in child protective services.

I explored with the mother, her belief about the effectiveness of corporal punishment. She stated that she believes that corporal punishment works best, citing her own childhood as an example. She explained that she was often hit as a child and it taught her not to misbehave "at least for a little while." She stated that her mother did not talk to her about her behavior or her feelings and resorted simply to physical punishment. However, she was able to discuss the negative impact her mother's discipline methods had on her. She stated that while the punishment was effective, her mother often "took things to far" and physically abused her. She reported "I still have the scars" and expressed the longstanding impact her mother's abuse had on her. After reflecting on her

own experience further, she expressed that she did not want to behave in the same way with her children.

I discussed with the parent how she felt when her children misbehaved. She expressed that she becomes very angry and will often yell. I explored with her the impact her yelling has on her sons. She then told a story about her youngest son who said out loud one day “nobody loves me.” When she assured him that she did love him, he replied “then why do you always yell at me.” She expressed that this exchange hurt her feelings considerably and she subsequently apologized to her son for the yelling. We then discussed ways in which anger can be destructive towards a relationship and I asked her what she could do differently to manage her anger. She was unable to identify any coping methods to manage her anger, so I provided her with a handout entitled “What can you do when you’re angry?” The handout provides such tips as:

- Recognize when you are becoming angry with your child, and leave the situation for 60 seconds.
- During that time, distract yourself with something else (do not think about what your child did to make you angry).
- Remind yourself that you do not have to be angry to handle the problem. Your anger will actually make the situation harder to handle.
- Decide how to deal with the situation
- Imagine yourself using the technique you chose in a calm manner.
- Return to your child and use the technique.
- Congratulate yourself for staying calm!

The parent was very receptive to the handout and felt that she could use these tools in her interactions with her sons. During the session we also discussed appropriate rewards and consequences for her sons’ behavior.

Session 12

The objective of the final session was to process the group as a whole and to congratulate participants on their engagement with the group. The agenda for the final group session included (1) group check in, (2) Review of discipline skills, (3) Review of the group, (4) complete the follow up parent survey. Four parents attended the final session.

Following the group check in, I reviewed discipline skills, such as setting limits and establishing clear and consistent consequences. Many of the parents reported that they learned these skills in previous parenting classes. I then moved the discussion to affect regulation and managing anger when children misbehave. Each parent identified that they had difficulty managing their anger when the children misbehaved. I reviewed again the handout “What can you do when you’re angry?” and explored other techniques that the parents have used to manage their anger.

Following the discussion, I provided each parent with a certificate. Parents who attended the majority of the sessions received a “certificate of completion.” The parents whose attendance was sporadic or who joined the group late received a “certificate of participation.” In addition, each parent received a parenting handbook with the various handouts and activities that had been used throughout the group.

Finally, each parent completed the follow up parent questionnaire, which was meant to help track parent’s progress. The questionnaire also provided them with an opportunity to identify what they liked and disliked about the group.

Challenges to group implementation

There were several challenges to implementing the group. For instance, group attendance was an issue as few members attended every group session. To encourage attendance, food was always provided and I would personally seek out each group member to remind them what time the group began. This was typically done by seeking out group members in the television lounge or in their apartments. This approach was met with some success as there were a few core group members who attended almost every group and a few members who attended sporadically. Group attendance ranged from one member to seven. The approach to group recruitment and retention was implemented on advice from staff members with experience running groups at the center. Other issues of concern during implementation included difficult group members, and conflict within the group. There were times when certain participants were either disruptive or domineering. For instance, during one session a new group member was often disruptive, interrupting the group leader and other group members, and asking questions unrelated to the topic. Attempts were made to address her questions and redirect her back to the topic, which met with varying degrees of success. In addition, this woman proclaimed several times throughout this particular session that “I already know these things... I always do these things with my child”; making a great show of what a “good parent” she was. The group leader attempted to encourage this member to share some of her positive experiences and ways in which she has implemented some of the parenting skills discussed in her own home. Despite these attempts to help her engage appropriately in the group, this member continued to be disruptive and eventually stormed out of the meeting. This is just one example of difficult group interactions.

In other instances there were conflicts between group members outside of session that affected their functioning in the sessions. To participants in particular had a disagreement over the course of the twelve week period and stopped speaking to each other. As a result, whenever the two were in a group session at the same time, one member would refuse to participate and would disengage from the group.

In addition to difficulties with participants, there were also some challenges with the staff. While staff often made attempts to be helpful during the implementation process, they had little time to devote to the project. This was particularly challenging as one of the The Family Center staff members was meant to act as a co-facilitator of the group. However, she was rarely available for collaboration and only attended half of the group sessions. This was somewhat concerning as it was my hope that she would replicate this group after my involvement with the project ceased.

Summary

This parenting program involved three components, which were, (1) Orientation of staff to program, (2) Recruitment of participants and (3) Parenting group. The parenting group ran over the course of twelve weeks. Attendance at group sessions was variable; however, there were a select group of parents who attended almost every session. Parents were typically engaged during group discussions and very forthcoming about their struggles with parenthood. Some of the skills taught during the group sessions were met with some skepticism, but participants remained open to learning and discussing the skills.

CHAPTER VII

PROGRAM EVALUATION

Abstract

This chapter presents an evaluation of the Attachment Based Parenting Program. This chapter follows Maher's (2000) framework for the program evaluation process, which is meant to determine the value of program. Findings from this evaluation will aid in determining ways in which the program can be improved. Three evaluation questions were asked and answered in this chapter. These questions are as follows: Who participated in the program? How was the program implemented with respect to participants? What appears to be the benefit of the program to participants? Major sections in this chapter include: Introductory Information, Program Evaluation Needs and Relevant Context, a brief description of the program, program evaluation questions, program evaluation protocols I-III, and an evaluation of the program evaluation.

Title of Program to be Evaluated

The title of the program to be evaluated is the Attachment Based Parenting Program.

Client, Relevant Stakeholders and Organization

Client

The identified client for this project is employed by a large not-for-profit organization that provides mental health and residential services to the seriously and

persistently mentally ill. The client served as the director of the supportive housing facility that is the focus of this dissertation for eight years. At the outset of this project, she was promoted from her position as director and was a full time employee. Her role was to supervise all staff at the Family Residential Programs and is the individual who identified a need for the program evaluation process. Given her position within the organization she was the appropriate person to serve as the identified client for this process.

Other relevant stakeholders

However, there were also other stakeholders affected by the program evaluation. These included the current Program Director of the residence; the support staff of the residence; the administrators of the organization. The current Program Director was responsible for daily operations at the residence and directly supervised all programs run at the residence. She was directly involved in allocating resources for the program evaluation process. The residents who participated in the program were also relevant stakeholders as the evaluation process involved asking them questions about their participation in the program.

Organization

The larger, parent organization is a not-for-profit organization that serves people with developmental disabilities and serious mental illness. The community organization aids this population by providing mental health, health and residential services in a large urban environment.

Of the numerous programs at the organization, there was one in particular that would benefit from program evaluation services. It is a community residence located in

an apartment building. It consisted of apartments for single-parent families and single adults. There is support provided for residents 24 hours a day and a number of service professionals who work to help consumers reach their goals. There are case managers on staff who work individually with residents, an entitlements counselor who works with residents to help them obtain necessary benefits (e.g. public assistance, SSI), child care workers who provide day care services, and a tutor who provides academic assessments and homework help for the school age children who reside in the apartment complex. The program identified for evaluation services was conducted by myself and a staff member of the residence.

Program Evaluation Needs and Relevant Context

Needs for Evaluation Services

In order to determine the client's needs for program evaluation information, the consultant met with client to discuss her reasons for requesting program evaluation services. No specific measure or survey was given to client during the meeting to assess her needs. In asking what the client wanted to know about the program, it was determined that she wished to assess who was served, if the program was implemented properly and if the participants benefited from the program.

Client Program Evaluation Needs

Table 26

Program Evaluation Needs- Current and Desired State of Affairs

Question	Current State of Affairs	Desired State of Affairs
Who	Client is unsure if the program addressed the appropriate target population	Client has knowledge as to whether the program addressed the appropriate target population.
How	Client is unsure whether the program was implemented according to the program evaluation	Client does know whether the program has been implemented according to design.
What	Client is unsure whether and to what extent the participants benefited from the program	Client does know whether and to what extent the participants benefited from the program

In discussions with the client, the question was asked “Why do you want this particular information about the program?” The client believes that gathering the above information will provide useful feedback on how well the program was implemented and whether it met the specified needs of the target population, which can be used to inform any possible changes or improvements that need to be made. Engaging in this program evaluation activity will also show the administration that the staff members of the residence are committed to providing quality services to their consumers.

Context Assessment

Purpose of Context Assessment

In order to design an appropriate program evaluation for the client an understanding of relevant contextual factors is necessary. Thus a context assessment was carried out using the AVICTORY approach. The methods used to carry out the assessment included meetings with key stakeholders and participant observation. The meetings were conducted with the current director of the residence and the client.

Contextual variables

The AVICTORY approach addresses eight key variables which can be used to assess context; these are ability, values, ideas, circumstances, timing, obligations, resistance and yield. Below each relevant variable will be addressed and detailed to assess the context for the program evaluation.

Ability

The ability of the Family Center to commit resources to the program evaluation process was limited. Major categories of resources include human, technological, informational, physical, financial and temporal.

Human Resources

There were limited human resources available to assist in the program evaluation process. While there were numerous individuals interested in and involved in this process, none of these individuals had a great deal of time to devote to this specific project.

There were also a number of individuals at the residence who were involved in the process, but difficulty scheduling meetings with them illustrated their limited amount of time. This was largely due to changes that occurred at the residence.

Technological/Informational resources

There was not a system in place for program evaluation and they did not have any validated measures that could be used to assess the program.

Physical Resources

Physical resources were limited. There was no office space available for the consultant to conduct the evaluation.

Financial Resources

The organization did not have additional funds available to evaluate this program. The program was conducted under the operating budget for the organization, which meant that office supplies and resources typically available for activities in the residence were used.

Temporal Resources

Staff and supervisors had little time to commit to the program evaluation process. The consultant had approximately two-three hours a week to dedicate to the evaluation process.

Values

The traditional and current values of the residence and larger organization are to serve the target population of families that reside there. It has always been important to provide quality service to this target population, particularly since it is such an underserved one.

Other values particularly important to staff at the residence were professional growth and development. As such, staff participated in trainings throughout the year to improve their skills. In addition, close attention was paid to the high incidence of burnout in the staff. Administrators took efforts to provide additional supports for the staff (e.g. regular meetings to process their concerns about the program and clients, opportunities to highlight the successes of the program rather than focusing on the failures).

Ideas

There were varying degrees of clarity about the task to be accomplished. The staff of the program design and evaluation department had a clear sense of the process and understood each step that must take place to complete the task. However, the client and other staff members of the residence were less clear about the task as they had never approached a problem from this perspective. They did have an understanding of what the end result will be (e.g. an evaluation of their program).

Circumstances

As stated previously, the residence underwent a period of transition during the completion of this project. The changes began in August of 2007 when the client was promoted from her position as Director of the residence. A new director was hired to take her place. Unfortunately this person left the position soon thereafter. Following her departure, one of the staff was promoted from her position to Director of the residence. Over the course of my work with the residence, a new person was hired as the Director of the residence; however, I had little contact with this person and continued to consult with the current director due to her ongoing involvement with the project. However, the organization's mission and strategic plan remained unchanged.

Timing

As mentioned previously, key administrators had limited time to commit to the program design process. There were funds available to pay relevant staff to implement the program, but there were limited funds for additional materials needed for the program. The financial resources needed to maintain the residence are obtained through a variety of city and state funds.

The changes in leadership and staff attrition at the residence suggest a potential problem for the evaluation process. The client and the current Director of the residence appeared open to the process and were willing to allow it to go forward. However, there was a chance that any more changes in the leadership or staff could hinder the progress of the project.

Obligations

It is clear that outside advocates (i.e. the program design and evaluation department) were active supporters of a programmatic approach. In addition, the other administrators involved (i.e. the client and the director) were supporters of any process that would help improve services offered to their consumers. Given their evolving understanding of the program design and evaluation process, they were not necessarily proponents of a programmatic approach, but were very invested in providing quality service to the target population. The staff of the residence had limited involvement in this process, but was similarly invested in providing quality service to their target population.

Resistance

Despite the commitment to providing quality service to the target population, there was some resistance to the program evaluation process. This was evidenced by the difficulty I had in meeting with the client and the director. This was likely a combination of many factors including their busy schedules and increased responsibilities. It was also possible that staff may object to another demand placed on their time and extra paperwork that may arise as a result of the evaluation process.

Yield

There is considerable benefit to the residence as a consequence of the evaluation. As mentioned, all stakeholders were invested in providing quality service to the target population. Thus the client and other administrators viewed the evaluation process as an opportunity to gain knowledge about the program that could be used to make any necessary changes and improvements.

Placing Program in Evaluable Form

The population of the residence consists of single parents with a history of homelessness and mental illness that have recently been reunified with their children. A portion of these individuals participated in the program. On a weekly basis, over the course of 12 weeks, the participating parents attended a parenting group designed to teach parents about attachment related issues. Through this program, parents learned ways to improve attachment and bonding between themselves and their children.

Program Design Elements

There were multiple components or phases to the program. These components included orientation of staff to the program, recruitment of parents to participate in the program, and the parenting group. Each phase will be explained fully.

Component I: Orientation of Staff to parenting group

Prior to the start of the group, I met with staff to provide an orientation. In order to begin the parenting group, staff members who interact with the parents needed to have an understanding of the group and its purpose. Once the staff members were able to have a clear understanding of the group and its purpose, they were able to help identify

potential participants for the group. The orientation took place during a regularly scheduled staff meeting for convenience.

Component II: Recruitment of parents to participate in program

Once staff members had an understanding of the group and its purpose, they were asked to recommend or refer parents to the group. Staff was encouraged to refer individuals whom they thought would benefit from the group, would be willing to participate and would be able to function in a group setting. This process served as a pre-screening for group participation.

Component III: Parenting Group

The parenting group was the part of the program that addressed the specific goals set forth in the purpose and goals section. The group was both process-oriented and skill based. Each session provided time to explore and process parents concerns about their current parenting issues. There was be an opportunity to discuss the role their mental illness and past relationship with their own caregivers affected in their parenting. The group also contained a skill building and psychoeducation component. Thus, parents learned about attachment and specific skills to help them improve the attachment between themselves and their children.

Summary

The program was previously designed by the consultant based on the specified needs of the client and target population. The program was divided into three components, with the initial component involving orientation of staff to the parenting group. Informing the staff about the group and what was involved in it allowed them to see the ways in which the information they provided during the needs assessment process was useful. It also made it easier for them to explain the group to their clients. As the staff had a clear sense

of the purpose of the group, they were more likely to 1) assist in the implementation process and 2) refer parents to the group. If the staff was not invested in the process, then it is unlikely that the parents would be. Once staff referrals were provided, potential participants were oriented to the program, which allowed an opportunity for the parents to address any questions or concerns they had and also provided an opportunity to verify whether they are eligible to participate. The final component involved the implementation of the parenting/attachment group, which was discussed at length above. When designed the program was created based on the framework presented in Maher's (2000) Resource Guide for Planning and Evaluating Human Service Programs. Thus the program is ready for evaluation and is placed in the appropriate evaluable form.

Program Evaluation Questions

In order to determine if the program was implemented properly and resulted in some form of change in the target population, an evaluation must be conducted. Three questions will be considered in order to assess the program. These questions are: Who participated in the program? How was the program implemented with respect to participants? What appears to be the benefit of the program to participants?

In order to determine the program evaluation questions, the consultant met with relevant stakeholders to discuss what they hoped to assess through the evaluation process. These three program evaluation questions were chosen because the client believes that gathering this information will provide useful feedback on how well the program was implemented and whether it is meeting the specified needs of the target population. This information can then be used to inform any possible changes or improvements that need to be made. The consultant determined that no formal interview or survey was needed to

determine the program evaluation questions. The information was gathered through discussions with relevant stakeholders who provided the necessary information.

Program Evaluation Protocols

Protocol I

Program Evaluation Question 1: Who participated in the program?

The answer to this question determined whether or not participants in the program were the same as or similar to the target population and met designated eligibility criteria.

Data Collection Variables

- participants in program meet eligibility criteria

Methods, Instruments, Procedures for Data Collection

The process for determining if program participants met eligibility criteria required multiple methods including permanent product review and interviews with key individuals. There were 6 eligibility criteria (See Table 27 for a review of methods, instruments, and procedures)

Table 27
Program Evaluation Protocol 1- Review of Methods, Instruments, and Procedures

Eligibility criteria	Methods	Instruments	Procedures
Is classified as severely and persistently mentally ill	Permanent Product Review	None	Review participants case file to determine his/her classification
Has already been reunified with their child(ren)	Face to face interview with parents	None	Ask each parent during the orientation if they have been reunified with their children
Has been referred by their case manager	Permanent Product Review	Referral list Attendance list for each group session	Review referral list, which will be created once referrals from case managers have been submitted. The referral list will be compared to the attendance list for the group.
Has participated in the program's orientation session	Permanent Product Review	Attendance List	Review attendance list for orientation session
Possesses a documented need in agreement with the determined needs of the target population	Administration of a survey	Initial Parent Survey	Responses to the initial parent survey will indicate certain areas of need that should correlate with the determined needs of the target population
Is in their own individual psychotherapy and attends regularly	Interview with key individuals	None	Ask prospective participants during the orientation session whether or not they are currently attending therapy

Methods and Procedures for Data Analysis and Interpretation

As the consultant and implementer of the evaluation plan, I was responsible for managing the data collected and analyzing it. The initial parent survey was administered and responses were reviewed to determine if the individual meets eligibility criteria. The responses were compared to the data included in the needs assessment report to determine if program participants possessed a documented need in agreement with the determined needs of the target population. In addition, a checklist was created for each participant to determine if he or she meets eligibility criteria (see Table 28).

Table 28
Eligibility Checklist

Eligibility criteria	Yes	No
Is classified as severely and persistently mentally ill		
Has already been reunified with their child(ren)		
Has been referred by their case manager		
Has participated in the program's orientation session		
Possesses a documented need in agreement with the determined needs of the target population		
Is in their own individual psychotherapy and attends regularly		

Program Evaluation Personnel, Responsibilities and Timelines

The program evaluation was completed by the program evaluator. The table below specifies the responsibilities and timeline for each task necessary to answer the first evaluation question (see Table 29)

Table 29

Evaluation Question 1- Personnel, Responsibilities and Timelines

Program Evaluation Question	Evaluation responsibilities	Personnel	Timeframe
Who participated in the program?	Review of referral list	Program evaluator	August 2008
	Review of attendance list for orientation session	Program evaluator	September 2008
	Question prospective participants during orientation session re: participation in individual therapy	Program evaluator	September 2008
	Review participants' case file to determine his or her classification	Program evaluator	September 2008
	Review responses to initial parent survey	Program evaluator	September 2008

Summary of Results

In total, 10 parents participated in the parenting group. Results indicate that only 20% of group participants met all eligibility criteria. 100% of group participants were classified as seriously and persistently mentally ill while only 50% of participants were reunified with their children at the time of group participation. Half of all participants (50%) were referred to the group by their case managers while the remaining half learned of the group from other participants. Only 40% of participants attended the orientation session. All participants possessed a documented need in agreement with the determined needs of the target population. Finally, only 60% of participants were in their own individual therapy (see table 30 for summary of results).

Table 30

Evaluation Protocol I- Summary of Results for Eligibility Criteria

Eligibility criteria	Percentage who met criteria
Is classified as severely and persistently mentally ill	100%
Has already been reunified with their child(ren)	50%
Has been referred by their case manager	50%
Has participated in the program's orientation session	40%
Possesses a documented need in agreement with the determined needs of the target population	100%
Is in their own individual psychotherapy and attends regularly	60%

Protocol II

Program Evaluation Question 2: How has the program been implemented with respect to participants?

The answer to this question will determine if the program was implemented as planned.

Data Collection Variables

- the program's eligibility criteria are used
- program follows the designated policy and procedures
- the designated methods, techniques, materials and facilities are used
- the phases occur in the planned order
- program implemented within designated budget constraints
- personnel perform assigned roles

Methods, Instruments, Procedures for Data Collection

The process involved in answering this particular evaluation question requires multiple methods including permanent product review, questionnaires and direct observation. See Table 31 below for a review of methods, instruments, and procedures.

Table 31
Program Evaluation Protocol II- Review of Methods, Instruments, and Procedures

Variables	Methods	Instruments	Procedures
Program's eligibility criteria are used	Administration of checklist	Program implementation checklist (<i>see Appendix F for a copy of the instrument</i>)	Designated staff completed this checklist to indicate if eligibility criteria have been met
Program follows the designated policy and procedures	Administration of checklist; Questionnaire	Program implementation checklist; Staff Reaction Survey (<i>see Appendix G for a copy of instrument</i>)	Designated staff completed this checklist. Selected staff also will complete a reaction survey to gather more information about their participation in the process and their feelings about how well it was implemented
Designated methods, techniques, materials and facilities are used	Administration of checklist, Questionnaire	Program implementation checklist; Staff reaction survey	Designated staff completed this checklist. Selected Staff also will complete a reaction survey to gather more information about their participation in the process and their feelings about how well it was implemented
Program phases occurred in planned order	Administration of checklist and questionnaire, permanent product review	Program implementation checklist, Staff reaction survey	Checklist and survey completed. Program evaluator reviewed any other records kept regarding the program to determine if the phases occurred in the planned order.
Program implemented within designated budget constraints	Permanent Product Review		Program evaluator reviewed any financial documents related to the implementation of the program
Personnel performed assigned roles	Questionnaire, direct observation	Staff reaction survey	Program evaluator will administer staff reaction survey and also observe the implementation process to determine if designated personnel have completed their assigned tasks.

Methods and Procedures for Data Analysis and Interpretation

I served as the program evaluator and intended to collect all completed staff reaction surveys and to review the program implementation checklist. The checklist was reviewed to determine which activities were completed. The initial plan was to review the surveys and to categorize each staff members' response by question. I then would review responses, noting similarities and differences in responses. I would then identify, analyze and determine themes that emerge from the responses.

Program Evaluation Personnel, Responsibilities and Timelines

The program evaluation was completed by the program evaluator. The table below specifies the responsibilities and timeline for each task necessary to answer the second evaluation question (see Table 32)

Table 32

Evaluation Question 2- Personnel, Responsibilities and Timelines

Program Evaluation Question	Evaluation Responsibilities	Personnel	Timeframe
How has the program been implemented with respect to participants?	Completion of program implementation checklist	Program evaluator	December 2008
	Completion of staff reaction survey	Direct Service Providers	Not completed
	Review of financial documents	Program evaluator	December 2008
	Observation of implementation process	Program evaluator	July 2008-December 2008

Summary of Results

As noted above, I initially intended to complete the program implementation checklist, review responses to the staff reaction survey, and review financial documents. A review of receipts and other financial documents indicates that the program did not exceed the budget delineated in the program design.

Changes were made to the evaluation plan as the project progressed. The primary change to the plan was the administration of the staff reaction survey. The staff survey was not completed as the staff had limited involvement in the implementation of the program. I determined, that much of the information that would be gathered from the staff reaction survey, could be gathered through my own observations and completion of the program implementation checklist.

Completion of the program implementation checklist (see Table 33 for completed checklist below) indicates that program activities were completed as intended. The checklist notes when each activity was completed. However, the checklist reveals that the program's eligibility criteria were only partially used as discussed above.

Table 33
Program Implementation Checklist: Program activities

Goals	Description of activity	Activity Completed?	Date Completed
Meet with administrator to discuss the parenting group and the curriculum	Discussion of the parenting group and the manner in which it should be presented to staff	Yes X No <input type="checkbox"/>	June 9, 2008
One hour meeting staff	Orientation meeting with staff to describe program and answer any questions	Yes X No <input type="checkbox"/>	July 11, 2008
Identify and recruit at least 6 parents who possess a documented need in agreement of the determined needs of the target population.	Identification and recruitment of clients	Yes X No <input type="checkbox"/>	July 11, 2008
Discuss group with interested parents, answer any questions, provide parent handout	Meet with identified parents to explain the attachment group	Yes <u>X</u> No <input type="checkbox"/>	September 23, 2008
Make direct service provider aware of potential participants	Provide names of potential group participants to direct service provider	Yes X No <input type="checkbox"/>	July 2008
Create appropriate curriculum for use in the psychoeducation group	Design curriculum for group	Yes X No <input type="checkbox"/>	July- October 2008
Identify/create materials needed for use in the implementation of the program	Determine necessary materials	Yes X No <input type="checkbox"/>	July-September 2008
Gain access to necessary materials	Obtain necessary materials	Yes X No <input type="checkbox"/>	July- September 2008
Ensure that direct service providers	Train direct service provider in proper	Yes X No <input type="checkbox"/>	August 2008

are adequately trained in the administration of the psychoeducation group	administration of curriculum		
Create a plan that will assess whether goals were met and program was implemented as planned	Design evaluation plan	<i>Yes</i> X <i>No</i> <input type="checkbox"/>	April 2008
Provide evaluator with training to ensure that he/she is able to implement the evaluation plan properly	Review evaluation plan with evaluator	<i>Yes</i> <input type="checkbox"/> <i>No</i> X	I served as program evaluator, so no training was needed
Provide a psychoeducation group that will meet the needs of the target population	Implement parenting group	<i>Yes</i> X <i>No</i> <input type="checkbox"/>	September-December 2008
Assess whether the program was successful	Implement evaluation plan	<i>Yes</i> X <i>No</i> <input type="checkbox"/>	June 2009

Table 34
Program Implementation Checklist: Overview

Program's eligibility criteria were used	<i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> Partially X
Program followed the designated policy and procedures	<i>Yes</i> <input type="checkbox"/> <i>No</i> <input type="checkbox"/> Partially X
Designated methods, techniques, materials and facilities were used	<i>Yes</i> X <i>No</i> <input type="checkbox"/>
Program phases occurred in planned order	<i>Yes</i> X <i>No</i> <input type="checkbox"/>

Review of the program implementation checklist also reveals that the program only partially followed the designated policies and procedures. See Table 35 below for a list of policy and procedures and the level of adherence to these procedures.

Table 35
Adherence to Policy and Procedures

Policies and Procedures	Procedure followed?
Only parents who meet all criteria for entrance into the program can participate	No, several parents did not meet eligibility criteria.
Parents will be referred to the program by staff members.	Only 50% of group participants were referred by staff members.
Because of the amount of material presented in each session, parents may not miss more than 3 of the 12 sessions.	No. Several members missed more than three sessions.
Parents will respect themselves and others in the group	Yes, group members were respectful of one another's opinions and statements
Parents will respect the confidentiality of those in the group	Yes, group members did not discuss the group content outside of meeting times.
During meetings parents are to participate and complete activity assignments	Yes, all parents participated in group discussions and completed activities. However, parents did not complete homework assignments presented in the group.
Parents will be willing to accept feedback from others without becoming verbally or physically aggressive/defensive	Yes, there were no incidences of verbal or physical aggression.
Parents will receive a certificate upon completion of the group	Yes. Parents who missed no more than three sessions received a certificate of completion. Parents who missed more than three sessions received a certificate of participation.
At the conclusion of the program, parents are to complete the parent questionnaire	Yes, all parents that were present for the final group completed the parent questionnaire. However, not all parents who participated in the group sessions over the course of the 12 weeks completed the questionnaire as they were not present for the final group session.

Protocol III

Evaluation Question 3: What are the benefits of the program for participants?

Data Collection Variables

- Program addresses the original SMART goals outlined in the program design.

Methods, Instruments, Procedures for Data Collection

In order to determine if the SMART goals were achieved, parents completed a parent survey during the first group session to establish a baseline level of functioning as well as to determine whether or not they possess needs in line with the documented needs of the target population. The parents also completed an additional survey at the end of the program participation to determine if any changes were made and describe what they may have learned from the group. Achievement of goals was also assessed through other methods, including permanent product review, and direct observation. See table 36 for a review of the methods, instruments and procedures.

Table 36
Program Evaluation Protocol III- Review of Methods, Instruments and Procedures

SMART Goals	Methods	Instruments	Procedures
Parents able to identify and articulate the parenting practices of their own caregivers and any ways in which these practices have influenced the way they parent their own children.	Direct observation, review of participant workbook; Interview	Participant workbook; Group Leader Interview (<i>see Appendix I for copy of instrument</i>)	Direct service provider noted when participants are able to do this during group sessions. Direct service provider reviewed participants' workbooks. Evaluator will interview direct service provider
By the end of the 12 week program participation period, parents will be able to clearly state at least one way in which their mental illness impacts their parenting abilities	Direct observation, review of participant workbook, Interview	Participant workbook; Group Leader Interview	Direct service provider noted when participants are able to do this during group sessions. Direct service provider reviewed participants' workbooks. Evaluator will interview direct service provider
Parents will be able to identify ways in which they are able to connect emotionally with their children and ways they are not able to do so.	Direct observation, review of participant workbook, Interview	Participant workbook; Group Leader Interview	Direct service provider noted when participants are able to do this during group sessions. Direct service provider reviewed participants' workbooks. Evaluator interviewed direct service provider
Parents will be able to identify and articulate at least one step they can take in improving their emotional connection with their children	Direct observation, review of participant workbook, Questionnaire	Participant workbook; Group Leader Interview, follow up parent survey	Direct service provider noted when participants are able to do this during group sessions. Direct service provider reviewed participants' workbooks
Parents will be able to articulate at least one reason why it is important to engage in play with their children	Direct observation, review of participant workbook; Questionnaire	Participant workbook; Staff interview, Follow up parent survey	Direct service provider noted when participants are able to do this during group sessions. Direct service provider reviewed participants' workbooks
Parents will be able to identify at least one play activity that they will engage in with their children by the end of the 12 week program period	Direct observation; Questionnaire	Follow up Parent surveys	Direct service provider noted when parents are able to identify a play activity during group sessions. Review of responses to parent survey
Parents will learn and articulate an understanding of appropriate discipline practices	Questionnaire, review of participant handbook, direct observation, interview	Initial and follow up parent surveys, group leader interview	Direct service provider noted when parents are able to identify appropriate discipline practices, Review of responses to parent survey.

Methods and Procedures for Data Analysis and Interpretation

Program evaluator collected the surveys that were completed pre- and post- group. Evaluator compared individual participant's responses on the pre- and post- group surveys to determine if any change has occurred. The answers provided by the group leader interview will be compared to the goals previously outlined to determine if any goals were met.

Program Evaluation Personnel, Responsibilities and Timelines

The program evaluation will be completed by the program evaluator. Specific tasks will be completed by the participants, the direct service provider and the program evaluator. The table below specifies the responsibilities and timeline for each task necessary to answer the second evaluation question (See Table 37).

Table 37

Evaluation Question 3- Personnel, Responsibilities and Timelines

Program evaluation question	Evaluation responsibilities	Personnel	Timeframe
What are the benefits of the program for participants?	Review of participant workbooks	Direct service provider	September – December 2008
	Administration of initial parent survey	Direct service provider	September 2008
	Administration of follow up parent survey	Direct service provider	December 2008
	Administrator of group leader interview	Program evaluator	December 2008

Summary of Results

This portion of the evaluation will determine if the original SMART goals outlined in the group design were addressed. Each SMART goal will be presented along with data gathered from a variety of sources (direct observation, interviews, and questionnaires) to determine if each goal was met. The results will be presented in both a tabular and narrative form.

As stated previously, a group leader interview was designed to gather feedback from those involved with facilitating the group. This interview provided an overall assessment of the group. As I was the primary group facilitator, I completed the group leader interview. However, I also received feedback from the staff member who assisted in the co-facilitation of some of the group sessions. Below is her response to the question “How do you feel the group went?”

“I feel the groups were productive in that it allowed the consumers to be honest with themselves, it gave them a place to vent their frustrations about parenting and establish new techniques in which to deal with their children’s developmental growth and a better understanding each of their children’s developmental task. It was clear to see that the group participants began to reach out for assistance within the program and resources outside of the program. The parenting groups provided parenting concepts that our consumers could understand and in a setting that was comfortable. In addition, because our participants parent and care for their families while functioning with a mental illness, the parenting groups provided insight, information they can utilize and that was realistic to their daily lives. You set the tone for many in that you maintained a professionalism, consistency, empathy and regular snacks that captured the interest and respect of the participants.”

Her response to this question reveals that overall the parents were receptive to the material presented, and learned some new skills. In addition, it provided an opportunity to process some of their frustrations and struggles with parenting. The staff member also

notes that the material was relevant and applicable to the participants' daily lives as parents.

SMART Goal 1. I will now review each SMART goal and assess the extent to which each goal was met. The first SMART goal for the program was that parents were able to identify and articulate the parenting practices of their own caregivers and any ways in which these practices have influenced the way they parent their own children. Achievement of this SMART goal was assessed via direct observation of the parenting group as well as the group leader interview. The relevant questions and responses from the group leader interview are presented in table 37 below. The findings indicate that the first SMART goal was indeed met.

Table 38
SMART Goal 1

Goal	Relevant questions from group leader interview	Response to questions from group leader interview
Parents able to identify and articulate the parenting practices of their own caregivers and any ways in which these practices have influenced the way they parent their own children.	Were parents able to identify and articulate how their own parenting history has affected the way they parent their children?	Parents were able to discuss ways in which their own parenting history impacted their emotional functioning as children and as adults. They were also able to note how their own parenting history impacted the way they parented their own children. For instance, one parent was able to comment on the fact that she was unable to provide physical affection to her son because she never received any as a child and it made her feel uncomfortable to do so. Several parents were able to comment on the negative patterns they have repeated with their children as one mother noted that she moved around considerably as a child and spent time in foster care, much in the same way her children have. Another parent was able to reflect on how her mother's substance abuse and lack of presence in the home was perpetuated in her own relationship with her children. Other parents discussed ways in which they actively avoided the damaging and problematic behavior their parents exhibited. One parent who had a history of physical and emotional abuse noted how hard she works to communicate openly with her children and to boost rather than damage their self-esteem.

SMART Goal 2. The second SMART goal was as follows: By the end of the 12 week program participation period, parents will be able to clearly state at least one way in which their mental illness impacts their parenting abilities. The attainment of this goal was assessed via direct observation, a review of participant's workbook and group leader interview. The relevant question and response from the group leader interview is presented in table 39 below. The response to the group leader interview suggests that this particular goal was only partially attained as not all members of the parenting group were able to clearly state ways in which their mental illness impacted their parenting abilities. This finding could have occurred for a number of reasons. For instance, parents who participated in the group had varying capacities for insight, differing levels of cognitive functioning and varying levels of symptom severity. It is possible that parents who were not able to attain this particular goal were impacted by at least one of these variables. Upon further reflection, this particular goal did not take all of these potential confounding variables into account.

Table 39
SMART Goal 2

Goal	Relevant Question from Group Leader Interview	Response to Question
By the end of the 12 week program participation period, parents will be able to clearly state at least one way in which their mental illness impacts their parenting abilities	Were all participants able to identify at least one way in which their mental health concerns interfered with their parenting?	Some parents during the group were more able to identify this than others. There were at least two parents who had limited insight into ways in which their mental illness impacted their parenting. Some were able to discuss ways in which previous periods of decompensation led to the removal of their children. One parent discussed in depth ways in which her long history of substance abuse affected her ability to be a present parent and ways in which her children continue to struggle to connect to and trust her even though she is currently sober.

SMART Goal 3. The third SMART goal is as follows: Parents will be able to identify ways in which they are able to connect emotionally with their children and ways they are not able to do so. The attainment of this goal was assessed through multiple methods. First, parents' responses to the relevant questions from the initial parent survey were reviewed. The relevant questions and their responses are listed in table 40 below. Secondly, responses to the group leader interview are also highlighted in table 41 below. Finally, responses to relevant questions from the follow up parent survey were also reviewed (see table 42).

Questions presented in the initial parent interview that assessed the parents' emotional connection included questions about physical affection, and talking to one's children about feelings. These questions were similar to those posed to the staff during the needs assessment process, and were chosen as they are more observable behaviors that can help to shed light on the connection between parent and child. Responses to the initial parent survey indicate that those parents who completed the survey were able to be physically affectionate with their children on a daily basis and made attempts to talk to their children when they were upset. However, many of the parents noted struggling with their own affective experience when faced with their children's distress. Responses to the initial parent interview, which can be seen in table 40, indicate that the parents felt a strong emotional connection to their children and made attempts to show their children affection on a daily basis. This was quite promising and indicated to me upon initial review, that the parents who completed the survey were likely to be open to discussions about attachment and interested in ways to continue to improve their relationships with their children.

Table 40

SMART Goal 3- Initial Parent Survey Questions and Responses

Question	No. of responses	Response
What is it like for you when your children are upset?	5	"Heart Wrenching"
		"Sometimes it's overwhelming"
		"It makes me feel bad also"
		"It makes me very emotional"
		"Hurtful... I don't like to see them cry"
How do you deal with your children when they are upset?	6	"We sit down and we talk about it"
		"I try to talk to my child to find out what is upsetting him"
		"I take time to speak with them about why they are upset"
		"Time out"
		"I give them time out and ask them to correct themselves"
		"I try to calm them down by talking to them and letting them know they can tell me what's wrong"
How often do you hug and kiss your children?	6	"Everyday when I get a chance"
		"My child knows he can get a hug and kiss whenever he wants"
		"Daily when they get up and before bed and as needed"
		"All day I hug and kiss them"
		"Almost everyday and I say I love you a lot too cause I believe that affection is very important"
		"Everyday"

While the initial parent survey was a useful tool to assess parents' baseline functioning, not all parents who participated in the group completed the initial parent survey. Thus, I learned of the struggles these parents had with the emotional connection to their children through group discussions. My understanding of the struggles these parents had with emotional connection to their children will be highlighted in the responses to the group leader interview (see table 41). The questions chosen for the group leader interview were meant to help me reflect on both the parents' initial struggles with establishing and maintaining an emotional connection as well as their ability to think about ways to improve this connection.

Table 41

SMART Goal 3- Relevant Questions and Responses from Group Leader Interview

Question	Response
Were they able to identify ways that they struggled to connect with their children?	Some parents over the course of several sessions, were able to reflect on the difficulties they had in providing physical affection, while others noted that they were at times uncomfortable engaging in play with their children. Many of the parents struggled with perspective taking and understanding their child's emotions. This particular issue came to light during the several sessions that focused on perspective taking.
Were the parents able to identify ways they were able to connect emotionally with their children?	Yes the parents were able to identify ways they are able to connect emotionally with their children. Several parents noted that they were very affectionate with their children and talked to their children frequently about their feelings. However, not all parents were able to identify ways that they connected to their children.

Very few parents completed the follow up parent survey. Only two parents fully completed the survey while one parent answered a fraction of the questions. Of the three parents who filled out the survey, only one attended group on a regular basis. This parent noted that she did feel that group discussions helped her think more about the emotional connection to her children. The two responses to the relevant question from the follow up parent survey are presented in table 42 below.

Table 42

SMART Goal 3- Relevant Questions and Responses from Follow Up Parent Survey

Question	Number of responses	Responses
Did group discussions help you think about the emotional connection you have with your children? How so?	2	“Yes... I think about our emotional connection all the time”
		“no”

Taken together, this data indicates that some of the parents who participated in the group were able to meet the stated goal as they were able to note both their struggles to connect with their children as well as ways in which they were able to do so. Thus, the third goal of the program was partially met.

SMART Goal 4. The fourth SMART goal for the program is as follows: parents will be able to identify and articulate at least one step they can take in improving their emotional connection with their children. This goal was assessed through review of the participant workbook, direct observation, the follow up parent interview and the group leader interview. During the group sessions, specific skills were introduced to help parents begin to improve their relationship with and connection to their children. These skills included talking to their children about their feelings, engaging in physical affection, and engaging in special playtime with their children. Overall, parents appeared to understand the concepts presented in the groups and the rationale for the skills taught. Many parents were able to articulate how at least one of the skills

and concepts taught during the group sessions could be used in improving their relationship with their child. Presented in the tables below are the responses to relevant questions from the follow up parent questionnaire and the group leader interview.

Table 43

SMART Goal 4- Relevant Questions and Responses from Follow Up Parent Questionnaire

Question	Number of responses	Response
What skills or ideas did you learn from the group that can improve your relationship/bond with your children?	2	“I learned that children have feelings that should be acknowledged and respected”
		“calm down, take a breath and listen”

The two responses noted above indicate different aspects of the parent training that the parents found helpful. The first response indicates that this parent feels that she has a better understanding of the importance of acknowledging her children’s feelings. This particular issue was highlighted over the course of several sessions that covered both perspective taking and the importance of talking to children about their feelings. The second parent’s response indicates that the parent identified the importance of calming herself down and listening to her child as a way to improve her relationship to her child. Table 44 presents the response to the relevant questions from the group leader interview.

Table 44

SMART Goal 4- Relevant Questions and Responses from Group Leader Interview

Question	Response
Were parents able to identify at least one way that they could improve the emotional connection with their children?	<p>Parents were presented with many different skills and activities meant to help them improve their connection to their children. One of the ways was through talking to their children about their feelings. The majority of the parents, who participated, noted during group sessions that they would work more to talk to their children about their feelings. However, they were unable to follow through on a homework assignment that required them to do just that. It appears that the parents left the group with an understanding of why it was important to talk to their children about their feelings and may increase the frequency with which they do so.</p> <p>While several of the parents struggled with the techniques from parent-child interaction therapy, they were able to understand ways in which play can positively impact their relationship with their children.</p>

Group discussions and responses to the surveys indicate that parents were able to identify at least one way to improve the connection with their children. Most parents indicated during discussions that the way they intended to begin to improve their relationship with their children would be through attempts to understand their children's emotional experience. They hoped to achieve this by talking more to their children about their feelings and experiences. Given this, it appears that this particular goal was met.

SMART Goal 5. The fifth goal of the program was that parents would be able to articulate at least one reason why it is important to engage in play with their children. This was assessed through my direct observation of group sessions. These observations revealed that during the sessions that focused on play and play therapy skills, many parents were initially reluctant to play with their children. They were even more reluctant to learn and use the PCIT skills taught during these group sessions. However,

all parents were able to generate some play activities that they were willing to do with their children, such as drawing, playing on the computer, or playing board games. Through their discussions of play activities, it became clear that they were aware of the benefits of playing with their children. However, only one parent responded to the question “What did you learn in the group about play?” when asked on the follow up parent survey. Her response was “I learned that play time is a good time to bond with your kids.” Thus, while the parents were able to appreciate the importance of play with their children, few of them were able to articulate a reason why it was important to do so. As a result, this particular SMART goal was not met.

SMART Goal 6. The sixth goal was as follows: Parents will be able to identify at least one play activity that they will engage in with their children by the end of the 12 week program period. As noted above, all parents were able to note at least one play activity to do with their children. Some of the activities identified included, playing board games, drawing, or playing videogames. No parents responded to the question “what is one play activity that you would consider doing with your child” asked on the follow up parent survey. The examples of play activities were generated during group discussions.

SMART Goal 7. The final goal for the group was as follows: Parents will learn and articulate an understanding of appropriate discipline practices. This was assessed through direct observation, the group leader interview as well as the initial and follow up parent surveys. The initial parent survey asked parents to describe what they do when their children misbehave. This question was asked to get a sense of what discipline practices the parents already use and what, if any, training they needed on appropriate discipline practices. Parents’ responses to this question indicated that many had a basic understanding of appropriate discipline practices. As can be seen

in table 45, the majority of parents utilized time out to manage misbehavior and did not utilize any corporal punishment. However, as was noted in the needs assessment, parents had difficulty managing their own feelings of anger and frustration when disciplining. This was evident during group discussions about discipline as many parents endorsed that they would become very angry and yell frequently when disciplining their children. Table 46 provides two of the responses from follow up parent surveys that indicate that parents were able to recognize the importance of managing their own affect before responding to their children's misbehavior. Finally, table 47 provides my response to the group leader interview and further detail about parent's discussions of discipline over the course of the group.

Table 45

SMART Goal 7- Relevant Questions and Responses from Initial Parent Survey

Question	Number of responses	Responses
What do you do when your children misbehave?	5	"Put them on time out"
		"Speak to them, time out, corners, take toys away"
		"Time out"
		"I tell them that I love them and mommy will be upset if you make me"
		"talk to them, put them in time out, take away toys or favorite thing"

Table 46

SMART Goal 7- Relevant Questions and Responses from Follow Up Parent Survey

Question	Number of responses	Responses
What skills or ideas did you learn from the group that can help with disciplining your child?	2	"Put myself on time out before I react."
		"to calm down... think about it"

Table 47
SMART Goal 7- Relevant Questions and Responses from Group Interview

Question	Response
What did parents learn about discipline practices?	Responses to the initial parent survey indicated that the majority of the parents were aware of appropriate discipline practices such as time out and restriction of privileges. I discussed in group sessions with them, the importance of positive reinforcement as well and labeled praise to increase the frequency of desirable and prosocial behavior. However, the majority of discussions about discipline focused on ways in which parents could manage their own affect when faced with behavior problems with their children. Many parents were able to note that they often became exceedingly angered by the misbehavior of their children and some often resorted to using hurtful language during these times. We discussed ways in which this can negatively impact a child and parents were provided with handouts that provided tools to decrease the intensity of their affect during these times. Parents were very receptive to these discussions and the handouts provided.

Findings from various measures reveal that the parents who participated in the program learned further skills that could aid them in disciplining their children. They were able to articulate in group discussions, and in responses to the parent surveys, their understanding of appropriate discipline practices. Therefore, this particular SMART goal was achieved.

Guidelines for Communication and Use of Program Evaluation Results

Audiences for program evaluation information

There are a number of individuals who have been involved in the program design, evaluation and implementation process and thus these individuals are the target audience for program evaluation information. The client is among this group. Others in the group include the current Program Director, the program implementer, the Director of Best Practices, and the Director of Evaluation.

Format for communication of program evaluation information

The program evaluator completed a written report outlining the data relevant to the three evaluation questions agreed upon with the client. The written report is in narrative form and includes tables and graphs. The evaluator will provide each stakeholder with the evaluation report, and will also provide a verbal outline of the report in a feedback session with the stakeholders.

Time periods for communication of program evaluation information

The written report was completed in February 2010. However, the evaluator held meetings in June 2009 with the Director of Evaluation and Director of Best Practices as well as with staff at the Family Center to provide preliminary feedback about the group. Staff were provided with an outline listing feedback and recommendations about the program. Staff at the Family Center and at the community organization will receive the complete evaluation report in May 2010.

Methods and procedures for use of program evaluation information

After the stakeholders are provided with the written report and have participated in the feedback session, they will have the opportunity to review the information independently. A follow up meeting will be scheduled to discuss the report and its implications for future programming. During the meeting the committee will discuss each evaluation question and determine for each question if the following occurred:

- A satisfactory result occurred
- A less than satisfactory result occurred
- A more than satisfactory result occurred
- An ambiguous result occurred

The committee will also determine what can be said about the results. Questions for the stakeholders to consider include:

- Is there a need for change?
- Should the program continue?
- Should the program be expanded or replicated?
- Should the program be terminated or phased out?

This process will allow the stakeholders to determine the answer to each evaluation question. Once these issues are addressed, the stakeholders can decide on a course of action regarding the program.

Evaluation of the Program Evaluation

Practicality – To what extent was the program evaluation conducted in a way that allowed for its successful accomplishment?

This question can be answered in a variety of ways. One useful method to employ is direct observation. The program evaluator observed the process to determine if the evaluation was completed in a practical manner. The evaluator will also conduct an informal interview during the feedback session with the key stakeholders to determine their feelings on the evaluation process.

Utility – In what ways was the resulting program evaluation information helpful to people? Which people?

The evaluator will also conduct an informal interview during a feedback session with the key stakeholders to determine their feelings on the utility of the evaluation information.

Propriety- Did the program evaluation occur in a way that adhered to legal strictures and ethical standards?

The program evaluator monitored herself throughout the evaluation process to determine whether ethical and legal guidelines are appropriately followed.

Technical Defensibility – To what degree can the evaluation be justified with respect to matters of reliability and validity?

The evaluation measures are not empirically validated as they were designed by the program evaluator. This is due to the fact that there was no validated instrument that was readily available that would suit the needs of this evaluation process. In addition, each measure designed is customized to assess this program design and the outcomes for this specific target population.

CHAPTER VIII

SUMMARY AND CONCLUSIONS ABOUT THE PROGRAM

Abstract

This chapter summarizes the program planning and evaluation process. Conclusions are presented for both the needs assessment and evaluation. Constraints of the study are noted and recommendations for further implementation of the program are made.

Need Assessment

The needs assessment conducted during the clarification phase of this dissertation focused on three domains: The psychological concerns of parents, parenting skills, and attachment. These domains were further subdivided. The psychological concerns of parents' domain assessed the impact of parental mental illness, parents' past history of abuse and poor parenting, and the effects of separation and reunification. The parenting skills domain assessed discipline skills, parents' ability to provide structure, and advocating for their children's educational needs. Finally, the attachment domain was assessed parents emotional connection to their children, ability to play with their children, and their ability to separate from their children.

Findings were generated through interviews conducted with staff. Several conclusions were drawn from the needs assessment interviews that were relevant to program planning. The needs assessment revealed that parents at the residence had significant past histories of trauma and poor parenting that negatively impacted their own skills as parents. Thus, it was determined that parents could benefit from the opportunity

to explore and process their own histories of trauma and gain insight into how it affects their own parenting. Additionally, the staff interviews indicated that many parents struggled throughout the reunification process and needed further support around this issue.

Assessment of the parenting skills indicated that the participants would benefit from learning affect management skills in order to communicate and discipline their children without screaming, yelling or name calling. Staff responses to the interview also indicated that parents could use support and training on how to set limits with their children.

In regard to attachment, the assessment indicated that many of the parents struggled to connect emotionally with their children as they at times had difficulty being affectionate with their children or understanding their children's feelings. Additionally, staff indicated that some of the parents in the residence rarely played with their children and had few positive interactions with them. Thus play was also identified as a target for intervention. The findings and conclusions from the needs assessment were then used to inform the design of the group curriculum.

Group Design

The parenting group ran for 12 sessions and included both insight oriented work as well as psychoeducation and skill building exercises. The group allowed members to process their feelings about their own histories as well as the impact separation and reunification had on their relationships with their children. The group curriculum was greatly informed by the attachment literature. Many of the insight oriented discussion questions were generated based on concepts in the attachment literature. In fact, some

discussion questions were taken directly from the Adult Attachment Interview created by Main & Goldwyn (1984). In addition, interventions and materials were drawn from several other attachment programs including the Circle of Security Project and the Compassion Workshop. Activities drawn from these two programs included handouts and activities designed to help parents learn to take their children's perspective and to learn to talk with their children about their feelings. Finally, parents were taught relevant skills Parent Child Interaction Therapy. Skills taught from the PCIT model included play therapy skills, to increase positive interactions between parents and their children, and discipline skills such as limit setting and affect regulation.

Implementation of the group

Initial groups focused on parents feelings about the separation from their children. During these groups parents discussed initial reasons for removal of their children from their care and ways this impacted them. These issues were difficult for some group members to discuss and members had varying levels of ability to tolerate the negative affect that resulted from this discussion. For instance, certain members tended to withdraw from the group discussion when they began to experience negative affect while other members were able to talk about their feelings. Attempts were made by the group facilitator to empathize with all group members and encourage those who withdrew to participate when they felt ready to do so. The group members were also at times able to act as support for one another throughout the groups.

Each member of this group was able and willing to discuss aspects of their childhood that had significant impacts on them. Members were often forthcoming with stories from their own childhoods. The group leaders also encouraged the members to

think about ways in which their upbringing has impacted their adult functioning and their roles as parents. Overall, the group members were very self-reflective and able to make connections about their past history and current functioning.

Following these sessions, there were several sessions focused on varying aspects of attachment. For instance, group discussions focused on difficulties in providing physical affection to one's children, understanding your child's emotions/perspective taking, engaging in positive activities with your child/engaging in play. The group facilitator utilized discussion questions, and group activities to begin to help parents learn the skills needed to take their child's perspective. This was difficult for some parents to do and is a skill that many were not able to master within the short amount of time available for the group. The group facilitator also introduced other activities and handouts designed to help parents think about/understand their children's emotions and begin to talk to their children about feelings. For instance, the group members were given a homework assignment to engage in a 5 minute conversation with their children about an event in the child's day that made them feel, happy, sad, or mad, and to write down a few words about what the experience was like for them. Unfortunately, while the parents' seemed initially receptive to the idea, none of them followed through with the homework assignment. When a group discussion was raised about reasons for this, most parents replied that they "forgot" or "didn't have time". The group leader attempted to explore the issue further but was met with resistance. The group leader encouraged the parents to attempt the homework assignment when they felt ready to do so. These assignments were all based mainly on the "circle of security project".

The group leader conducted groups about the importance of play and how it can be used to improve relationships/attachment between parents and children. The consultant/group leader used the Parent Child Interaction Therapy model (PCIT) to provide parents with a brief training on play therapy techniques that they can use with their children at home. PCIT attempts to improve parent-child relationships through teaching parents the fundamental relationship-building techniques used by play therapists. These techniques include describing what a child is doing; reflecting appropriate speech and feelings, and praising appropriate behaviors.

The play therapy sessions were met with skepticism by most parents who were either uncomfortable or unwilling to engage in play with their children. The group leader explained to parents the purpose of engaging in play and explored with parents their hesitation to do so. The rules/skills of PCIT were reviewed and practiced through role-plays. Some of the skills were met again with skepticism, particularly the reflection skills, but the parents made attempts to role-play the skills after much prompting and responded to corrections made by the group leader. Parents were encouraged to introduce these play therapy skills at home through a “special playtime” with their children. This was met with reluctance, so the group had a discussion about the reasons for the reluctance and ways that they can incorporate the idea of special playtime and the ensuing skills, into interactions they already have with their children, which seemed more acceptable to the parents. The remaining group sessions focused on discipline issues and managing anger when interacting with their children.

Challenges

There were many challenges faced during the implementation of the group. For instance, facilitating consistent attendance at group sessions was often quite difficult. In order to encourage attendance at groups, food was always provided by the group facilitator. In addition, the facilitator personally sought out each group member each week to remind them of the group and to encourage them to attend. This was typically achieved by talking to group members either in the television lounge of their residence or knocking on the doors of their apartments. This approach met with some success as there were a few core group members who attended almost every session, and some members who attended sessions sporadically. Group attendance ranged from one parent to seven over the course of the 12 weeks.

At times during group sessions, the facilitator also had to manage difficult group members, and conflict between group members. For instance, there were times when certain participants were either disruptive or domineering. Certain group members, when present, tended to take control of group discussions, which resulted in other group members feeling silenced or left out. At other times, certain members were disruptive throughout the group and made it difficult for other group members to focus and learn the skills being presented. Attempts to manage these problematic behaviors were often unsuccessful.

Upon reflection, it is evident that the 12 weeks did not present enough time to adequately address the materials presented in the group. It was often difficult to get through all material planned for each session, so often a topic that was only intended for one session, required two or three sessions to be adequately addressed. Thus, it felt that

the facilitator had to rush through teaching certain skills (e.g. play therapy skills, discipline skills) due to time constraints.

Another challenge that arose during the group implementation was the availability of staff. For instance, the group was intended to be facilitated by two individuals, this researcher, and a staff member from the residence. However, this staff member was only able to be present for approximately half of the group sessions. The staff member's availability was often limited due to the many responsibilities and demands she had to manage in her position. The primary purpose of co-facilitating the group with a staff member was to ensure that the group could be replicated by staff once the researcher was no longer involved with the agency. The staff member's reduced presence at group sessions and limited involvement in curriculum development decrease the likelihood that the group will be replicated at the residence.

Factors that positively affected group implementation

Despite the many challenges faced over the course of the 12 weeks, group was able to be implemented. There were a few factors that aided in group implementation. Particularly useful was the meeting that this researcher had with staff members at the residence prior to implementing the group. During this meeting, the researcher and staff discussed possible challenges to implementing the group. The staff members were able to anticipate many of the challenges described in the previous section and provided the researcher with useful advice to address the challenges. For instance, staff members stressed the importance of providing food at each group session as an incentive for group participants. In addition, they suggested that the facilitator personally seek out each group participant prior to each group to remind them of the day's session.

Evaluation

In order to assess the value of the program, an evaluation plan was designed and implemented. Three questions were considered in order to assess whether the program added value to the target population: Who participated in the program? How was the program implemented with respect to participants? What appears to be the benefit of the program to participants?

Evaluation Measures

The evaluation plan utilized a number of measures to assess the effectiveness of the program. Each interview and or questionnaire was designed by the consultant as there was no validated instrument that was readily available and that would suit the needs of this evaluation process. In addition, each measure designed was customized to assess this program design and the outcomes for this specific target population.

The program implementation checklist is a form designed to assess whether or not each activity outlined in the program components section has been completed. There is also a short section in the checklist to indicate whether or not specific aspects of the program design have been utilized (e.g. eligibility requirements). This form provides an uncomplicated method for determining if the program was implemented as planned, and again, is customized to this particular program design process.

The group leader interview asked a series of questions to gather feedback about the group facilitator's feelings about the effectiveness of the program. The parent surveys, presented pre- and post group were designed to assess whether or not the program goals have been met.

Evaluation Results

The evaluation revealed that the majority of participants did not meet the eligibility criteria for participation in the program. Completion of the program implementation checklist described above indicates that program activities were completed as intended.

Several conclusions can be drawn about the value the program provided for participants. The participating parents were able to gain insight into the connection between past experiences (e.g. childhood experiences of abuse, trauma and poor parenting) and their current parenting practices. In addition, many parents were able to articulate their strengths and weaknesses related to their ability to connect with their children. The parents were also able to learn new skills that would begin to strengthen attachment between themselves and their children. These skills included helping their children share and express their feelings, and engaging in fun play activities with their children. The parents did not, however, achieve a strong grasp on the parent child interaction skills taught during the group sessions. Finally, parents were able to identify appropriate discipline practices and were engaged and open to discussions about affect regulation and ways that learning skills to manage their anger could benefit their relationship with their children.

Constraints of the investigation

There are two constraints of the study, which are the lack of external validity and the evaluation methods used. This dissertation is a case study with a small sample of participants ($n=10$) at a supportive housing residence that were not randomly selected. Thus the data collected during the needs assessment and evaluation is not generalizable to the larger population of single parents with a history of mental illness.

In addition, the methods used for the needs assessment and evaluation process were of a qualitative nature and utilized questionnaires and interviews created by this researcher. The data generated was based on perceptions and subjective opinions of those interviewed rather than on quantitative and objective methods. Each interview and or questionnaire was designed by the consultant as there was no validated instrument that was readily available that would suit the needs of this evaluation process. In addition, each measure designed is customized to assess this program design and the outcomes for this specific target population.

Recommendations

The Attachment Based Parenting Program appeared to provide some value to the participants as it helped to increase awareness about attachment issues and taught parents useful skills to improve their relationship with their children. Thus it is recommended that group be replicated at the residence to assist other parents. However, some alterations should be made to make the group more effective.

For instance, some of the skills and activities taught during the group should be further adapted to suit the needs of parents with older children. While the majority of the parents who participated in the group had children under the age of 6, a few members had

pre-adolescent or adolescent children. During group discussions, I was able to help these parents with older children identify ways in which the activities and skills could be adapted and incorporated into their regular routines and interactions with their children. However, it would be useful for the skills and activities to be more formally adapted to more adequately meet the needs of parents with older children.

In addition, the parent-child interaction therapy skills taught during the group were useful, but were not initially well received. The materials and skills presented should be adapted to be more culturally sensitive to the families participating in the program. The skills should also be taught over a longer period of time to allow more discussion and practice of each skill. For instance, it could be useful to teach and practice one PCIT skill per session.

The group could also benefit from being longer than 12 sessions. This would allow more time for parents to process and discuss their own histories as well as more time to discuss and practice the parenting skills presented over the course of the group. If the group is to be replicated at the residence, it is important to choose an appropriate group facilitator. Ideally, this person would have both experience working with seriously and persistently mentally ill adults as well as experience working with children. This is important as a group facilitator would need to understand this particular population of parents and the particular challenges they face given their histories and struggles with mental illness. Experience working with children is also valuable as it is difficult to teach parenting skills with little knowledge of child development. In addition, the parents who participated in the program were more open to my suggestions and discussions because they were aware of my experience working with children. It also important to have some

experience working with children and using play therapy as these are the skills that will be taught to parents over the course of the group. In addition, the person should have some understanding and knowledge of attachment theory as it is the core theoretical underpinning for the interventions conducted.

As the regular staff at the residence is quite overburdened it would be useful to bring in a graduate student to run such a group. This would likely be less of a financial burden for the organization. Additionally, a graduate student either in psychology or social work would likely have the basic clinical skills needed to run such a group. It would also be useful for the group facilitator to be present at the residence more frequently than I was able to be. This would allow the person to interact with the parents and staff on a more regular basis and potentially follow up with parents regarding the skills learned during group sessions.

Summary

This dissertation focused on the design, implementation and evaluation of a program for parents with a history of mental illness who have been separated from their children. The needs assessment results indicated that the parenting group should provide parents with an opportunity to process their own attachment history as well as to learn appropriate discipline practices and skills to improve the attachment between themselves and their children. The discussion questions and interventions presented throughout the parenting group were based on attachment theory and other attachment based programs. Implementation of the parenting group provided some challenges. Primary among these challenges was recruitment and retention of participants. After following advice provided by staff members, I was able to recruit 10 parents to participate in the program.

However, only a select few of these parents regularly attended session despite my frequent efforts to reach out to parents and encourage them to attend. Other challenges that occurred during the implementation process included the availability of staff members, conflict between group members, and time constraints.

Despite several challenges, many parents were able to benefit in some way from participation in the group. Evaluation results indicate that parents were able to gain insight into their own attachment histories, and to identify new ways to bond with their children through play and by making attempts to understand their children's emotional experience. However, given the nature of the evaluation procedures used (e.g. qualitative rather than quantitative assessment tools) these results are not necessarily generalizable to similar populations. In addition, despite the value added to the participants, the program could be improved considerably, both in terms of fidelity to the program design and increased opportunity for practice and internalization of new skills.

REFERENCES

- Ackerson, B. J. (2003). Coping with the dual demands of severe mental illness and parenting: The parents' perspective. *Families in Society: The Journal of Contemporary Human Services*, 84(1), 109-118. doi: 10.1606/1044-3894.69.
- Ahern, K. (2003). At risk children: A demographic analysis of the children of clients attending mental health community clinics. *International Journal of Mental Health Nursing*, 12, 223-228.
- Bellamy, J. L. (2008). Behavioral problems following reunification of children in long-term foster care. *Children and Youth Services Review*, 30, 216-228.
doi:10.1016/j.childyouth.2007.09.008.
- Besser, A. & Piel, B. (2005). The apple does not fall far from the tree: Attachment styles and personality vulnerabilities to depression in three generations of women. *Personality and Social Psychology Bulletin*, 31, 1052- 1073.
- Cordero, A. E. (2004). When family reunification works: Data-mining foster care records. *Families in Society: The Journal of Contemporary Social Services*, 85(4), 571-580. doi: 10.1606/1044-3894.1840.
- Eyeberg, S. (1999). *Parent-child interaction therapy: Integrity checklist and session materials*. Unpublished manuscript, Child Study Laboratory, Department of Clinical Health Psychology, University of Florida, Gainesville, Florida.
Retrieved from <http://pcit.php.ufl.edu/>.
- Feeney, J. A., Noller, P., & Roberts, N. (2000). Attachment and close relationships. In C. Hendrick & S. S. Hendrick (Eds.), *Close Relationships: A Sourcebook* (pp. 185 – 201). Thousand Oaks, CA: Sage Publications.

- Fonagy, P., Steele, M., Steele, H., Higgitt, A., & Target, M. (1994). The theory and practice of resilience. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 35, 231-257.
- Garza, Y., Watts, R. E. & Kinsworthy, S. (2007). Filial therapy: A process for developing strong parent-child relationships. *The Family Journal: Counseling and Therapy for Couples and Families*, 15(3), 277-281.
doi:10.1177/1066480707301374.
- Gauthier, Y., Fortin, G., & Jeliu, G. (2004). Clinical application of attachment theory in permanency planning for children in foster care: The importance of continuity of care. *Infant Mental Health Journal*, 25(4), 379-396. doi: 10.1002/imhj.20012.
- Grienenberger, J., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother-infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational transmission of attachment. *Attachment & Human Development*, 7(3), 299-311.
doi: 10.1080/14616730500245963.
- Greif, G. L. & Ephross, P. H. (2005). *Group work with populations at risk* (2nd ed.). New York: Oxford University Press.
- Haight, W. L., Kagle, J. D., & Black, J. E. (2003). Understanding and supporting parent-child relationships during foster care visits: Attachment theory and research. *Social Work*, 48(2), 195-207.
- Hammen, C. (2003). Risk and protective factors for children of depressed parents. In S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 50-75). Cambridge: Cambridge University Press.

- Heese, E. (1999). The adult attachment interview: Historical and current perspectives. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (pp. 395-433). New York: Guilford Press.
- Hines, A. M., Lee, P. A., Osterling, K. L., Drabble, L. (2007). Factors predicting family reunification for African American, Latino, Asian and White families in the child welfare system. *Journal of Child and Family Studies*, 16, 275-289. doi: 10.1007/s10826-006-9085-2
- Hipwell, A. E., Goossens, F. A., Mehuish, E. C. & Kumar, R. (2000). Severe maternal psychopathology and infant-mother attachment. *Development and Psychopathology*, 12, 157-175. doi:10.1017/S0954579400002030
- Hoffman, D. & Rosenheck, R. (2001). Homeless mothers with severe mental illnesses and their children: Predictors of family reunification. *Psychiatric Rehabilitation Journal*, 25(2), 163-169.
- Howe, D. (2006). Developmental attachment psychotherapy with fostered and adopted children. *Child and Adolescent Mental Health*, 11(3), 128-134. doi: 10.1111/j.1475-3588.2006.00393.x.
- Howe, D. & Fearnley, S. (2003). Disorders of attachment in adopted and fostered children: Recognition and treatment. *Clinical Child Psychology and Psychiatry*, 8, 369- 387. doi: 10.1177/1359104503008003007.
- Jernberg, A. (1984). Theraplay: Child therapy for attachment fostering. *Psychotherapy: Theory, Research, Practice, Training*, 21(1), 39-47. doi: 10.1037/h0087526

- Johnson, B. D., Franklin, L. C., Hall, K. & Prieto, L. R. (2000). Parent training through play: Parent-child interaction therapy with a hyperactive child. *The Family Journal: Counseling and Therapy for Couples and Families*, 8(2), 180-186.
doi:10.1177/1066480700082013.
- Juffer, F., Bakermans-Kranenburg, M. J., & Van IJzendoorn, M. H. (2005). The importance of parenting in the development of disorganized attachment: Evidence from a preventive intervention study in adoptive families. *Journal of Child Psychology and Psychiatry*, 46, 263-274. doi: 10.1111/j.1469-7610.2004.00353.x
- Kenrick, J. (2000). 'Be a kid': The traumatic impact of repeated separations on children who are fostered and adopted. *Journal of Child Psychotherapy*, 26(3), 393-412.
doi: 10.1080/00754170010003615.
- Kobak, R., Cassidy, J., Lyons-Ruth, K. & Ziv, Y. (2006). Attachment, stress, and psychopathology: A developmental pathways model. In D. Cicchetti & J. Donald (Eds.), *Developmental psychopathology: Vol 1. Theory and method* (2nd ed., pp. 333-369). Hoboken, NJ: John Wiley & Sons.
- Leathers, S. J. (2003). Parental visiting, conflicting allegiances, and emotional and behavioral problems among foster children. *Family Relations*, 52, 53-63.
[doi:10.1111/j.1741-3729.2003.00053.x](https://doi.org/10.1111/j.1741-3729.2003.00053.x).
- Maher, C. (2000). Resource guide for planning and evaluating human services programs. Unpublished Manuscript.
- Main, M. (n.d.) Adult Attachment Interview Protocol. Retrieved from
http://www.psychology.sunysb.edu/attachment/measures/content/aai_interview.pdf.

- McWey, L. (2004). Predictors of attachment styles of children in foster care: An attachment theory model for working with families. *Journal of Marital and Family Therapy*, 30(4), 439-452. doi: 10.1111/j.1752-0606.2004.tb01254.x
- McWey, L. M. & Mullis, A. K. (2004). Improving the lives of children in foster care: The impact of supervised visitation. *Family Relations*, 53, 293-300. Retrieved from <http://www.jstor.org/stable/3700347>.
- Mercer, J. (2006). *Understanding attachment: Parenting, child care, and emotional development*. Westport, CT: Praeger Publishers.
- Oosterman, M. & Schuengel, C. (2007). Autonomic reactivity of children to separation and reunion with foster parents. *Journal of American Academy of Child and Adolescent Psychiatry*, 46(9), 1196-1203. doi: 10.1097/chi.0b013e3180ca839f.
- Pade, H., Taube, D. O., Aalborg, A. E., & Reiser, P. J. (2006). An immediate and long-term study of a temperament and parent-child interaction therapy based community program for preschoolers with behavior problems. *Child & Family Behavior Therapy*, Vol. 28(3), 1-28. doi: 10.1300/J019v28n03_01.
- Powell, C., Cooper, G., Hoffman, K. & Marvin, R. (2007). The circle of security project: A case study – “It hurts to give that which you did not receive”. In D. Oppenheim & D. F. Goldsmith (Eds.), *Attachment theory in clinical work with children* (pp. 172-202). New York: Guilford Press.
- Risley-Curtiss, C., Stromwall, L. K., Hunt, D. T., & Teska, J. (2004). Identifying and reducing barriers to reunification for seriously mentally ill parents involved in child welfare cases. *Families in Society: The Journal of Contemporary Social Services*, 85(1), 107-118. doi: 10.1606/1044-3894.240.

- Ryan, V. (2007). Filial therapy: Helping children and new carers to form secure attachment relationships. *British Journal of Social Work*, 37, 643-657.
doi:10.1093/bjsw/bch331
- Schofield, G. (2002). The significance of a secure base: A psychosocial model of long-term foster care. *Child and Family Social Work*, 7, 259-272.
- Seifer, R. (2003). Young children with mentally ill parents. In S. Luthar (Ed.), *Resilience and vulnerability: Adaptation in the context of childhood adversities* (pp. 29-49). Cambridge: Cambridge University Press.
- Stosny, S. (1995). *Treating attachment abuse: A compassionate approach*. New York: Springer Publishing.
- Taussig, H., Clyman, R. B., & Landsverk, J. (2001). Children who return home from foster care: A 6-year prospective study of behavioral health outcomes in adolescence. *Pediatrics*, 108(1), e10. doi: 10.1542/peds.108.1.e10.
- Timmer, S. G., Urquiza, A. J., Herschell, A. D., McGrath, J. M., Zebell, N. M., Porter, A. L. & Vargas, E. C. (2006). Parent-child interaction therapy: Application of an empirically supported treatment to maltreated children in foster care. *Child Welfare*, 85(6), 919-939.
- Van Ecke, Y., Chope, R. C. & Emmelkamp, P. M. (2006). Bowlby and Bowen: Attachment theory and family therapy. *Counseling and Clinical Psychology Journal*, 3(2), 81- 108.
- Watts, R. E. & Braddus, J. L. (2002). Improving parent-child relationships through filial therapy: An interview with Garry Landreth. *Journal of Counseling & Development*, 80, 272-379.

- Webb, L. P. & Leehan, J. (1996). *Group treatment for adult survivors of abuse: A manual for practitioners*. Thousand Oaks, CA: Sage Publications, Inc.
- Whiting, J. B. & Lee, R. E., III. (2003). Voices from the system: A qualitative study of foster children's stories. *Family Relations*, 52, 288-295.
[doi: 10.1111/j.1741-3729.2003.00288.x](https://doi.org/10.1111/j.1741-3729.2003.00288.x).

APPENDIX A

Target Population Interview Protocol

- Number
 - How many families live at the residence?
 - How many families are there with one child?
 - With two?
- Age
 - What is the age range of the parents?
 - How many parents in each age range?
 - What is the age range of the kids?
 - How many kids are in each age range?
- Gender
 - Gender of parents? How many single parent fathers? Mothers?
 - Gender of kids? How many boys? Girls?
- Ethnicity
 - What are the ethnic backgrounds of the families that live here?
- Diagnoses
 - What are the diagnoses of the parents who live here? (Can be a range; don't have to know every single one?)
 - Around how many parents also have concurrent substance abuse issues?

APENDIX B

Interview Protocol for Needs Assessment

Introductory information

- What do you think of the parent-child interactions here at the residence? (*Can you give me a sense of the quality of parent-child interactions here?*)
- What do you think impacts the residents' ability to parent?
 - What enhances parenting?
 - What gets in the way?

Reunification process

- What is the length of time that parents have been separated from their children?
- What kind of issues/challenges come up as a result of the reunification process?
- Can you tell me a little about why the children were originally taken away from their parents?

Childcare

- Are parents actively involved in child care?
- What factors interfere with parents being involved in childcare?
- What steps have been taken to increase parents' involvement?

Discipline

- How do parents at the residence currently discipline their children?
- Are there any skills that parents could use to help discipline their children more effectively? (e.g. setting clear limits, establishing consequences for misbehavior, providing positive reinforcement for good behavior)
 - If so, what are they?

Structure

- What kind of structure do the parents' provide for their children?
 - Are they able to get their children to school on time?
 - What are the bed time habits like for the children?
 - Are parents able to make sure homework is completed?
 - Do parents have planned meal times for their children?

Advocating for educational needs

- What have you noticed about parents' interactions with their children's schools?

Parents' mental health

- How do you think the parents' mental illness affects their parenting?
 - Are the parents able to recognize this?
- Are the parents able to manage the symptoms of their mental illness?

Play

- What kinds of play activities do the parents engage in with their children?
- What other positive activities do they engage in with their children?
- How often do these types of activities occur?

Emotional Connection

- What have you noticed about the parents' emotional connection with their children?
- What can you tell me about the children's emotional connection to their parents?
- Are there some parents with whom you've seen a good connection with their children?
 - What does that look like?
- What can you tell me about physical affection between the parents and their children?
- What have you noticed about parents' ability to understand their children's feelings?
- How are parents at recognizing when their children need to be comforted and reassured?

Separating from children

- Are there any parents who have difficulty separating from their children?
 - What does that look like?
- Are there children who seem to have difficulty separating from their parents?
- What can be done to help parents who struggle with this issue?

Relationship with their own caregivers

- What can you tell me about the parents' experiences with their own caregivers?
- How do you feel the parents' past relationship with their own caregivers affects how they parent their own children?
 - Are they able to talk about this?
- What do you think can be done to help the parents with these issues?

APPENDIX C

Attachment Based Parenting ProgramOverview of Program

After interviewing staff members to assess the needs of parents at the Family Center, it appears that there are issues around attachment between the parents and their children. It seems that some of the parents at the Family Center struggle with connecting to and bonding with their children. A program has been developed to address these attachment related needs. On a weekly basis, over the course of 12 weeks, the participating parents will attend a parenting group designed to teach parents about attachment related issues. Through this program, parents will learn ways to improve attachment and bonding between themselves and their children.

Goals of the program

The program is designed with the overall goal to provide parents with knowledge and skills that can help improve their relationships with their children. Through participation in the group, parents should learn/accomplish the following:

- To identify and articulate the parenting practices of their own caregivers and any ways in which these practices have influenced the way they parent their own children.
- To identify ways in which their mental health concerns interfere with their ability to parent
- To identify ways in which they are able to connect emotionally with their children and ways they are not able to do so.
- To identify and articulate at least one step they can take in improving their emotional connection with their children
- To articulate at least one reason why it is important to engage in play with their children
- To identify at least one play activity that they will engage in with their children

It is hoped that through participation in the program and the accomplishment of these goals, parents at the residence will have taken a small step towards strengthening their bond with their children.

APPENDIX D

Attachment Based Parenting Program DescriptionIntroduction to the program

The new Attachment Based Parenting Program is designed for parents like you, who want to improve their relationship with their children. The program offers a place for you to get support, feedback and useful tips to help you improve your relationship with your children. You will be able to ask questions of the program leader as well as talk with other parents who may have had similar experiences as you. Participating in the program is a good first step towards improving your relationship with your children.

Program Details

The program consists of a group that meets every week for 12 weeks. It will take place in the Community Room at The Family Center.

APPENDIX E

Parent questionnaire

Name: _____

Date: _____

Introduction: This is a brief questionnaire meant to help me get to know you better. Please answer the questions to the best of your ability. Your answers to these questions will help me understand what areas you need help with and what other information I should include in the group.

1. Please list 5 words to describe your relationship with your children.

2. Please list one thing you would like to change about your relationship with your child.

3. Please list one good thing about your relationship with your child.

4. What is it like for you when your children are upset?

5. How do you deal with your children when they are upset?

6. How often do you hug and kiss your children?

7. How often do you play with your children?
8. What kinds of activities do you and your children do together?
9. What is it like to play with your kids?
10. What do you do when your children misbehave?
11. What is one thing you are really good at in terms of parenting?
12. What is one thing you still need help with in terms of parenting?

APPENDIX F

<i>Program Implementation Checklist</i>

Program activities

Goals	Description of activity	Activity Completed?	Date Completed
Meet with administrator to discuss the parenting group and the curriculum	Discussion of the parenting group and the manner in which it should be presented to staff	Yes <input type="checkbox"/> No <input type="checkbox"/>	
One hour meeting staff	Orientation meeting with staff to describe program and answer any questions	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Identify and recruit at least 6 parents who possess a documented need in agreement of the determined needs of the target population.	Identification and recruitment of clients	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Discuss group with interested parents, answer any questions, provide parent handout	Meet with identified parents to explain the attachment group	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Make direct service provider aware of potential participants	Provide names of potential group participants to direct service provider	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Create appropriate curriculum for use in the psychoeducation group	Design curriculum for group	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Identify/create materials needed for use in the implementation of the program	Determine necessary materials	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Gain access to necessary materials	Obtain necessary materials	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Ensure that direct service providers are adequately trained in the administration of the psychoeducation group	Train direct service provider in proper administration of curriculum	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Create a plan that will assess whether goals were met and program was implemented as planned	Design evaluation plan	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Provide evaluator with training to ensure that he/she is able to implement the evaluation plan properly	Review evaluation plan with evaluator	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Provide a psychoeducation group that will meet the needs of the target population	Implement parenting group	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Assess whether the program was successful	Implement evaluation plan	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Other programmatic issues

Program's eligibility criteria were used	Yes <input type="checkbox"/> No <input type="checkbox"/>
Program followed the designated policy and procedures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Designated methods, techniques, materials and facilities were used	Yes <input type="checkbox"/> No <input type="checkbox"/>
Program phases occurred in planned order	Yes <input type="checkbox"/> No <input type="checkbox"/>

APPENDIX G

Staff Reaction Survey

1. What was your role in the implementation of this program?

2. Did you feel that the program proceeded according to plan?
 - a. If so, how was staff able to accomplish this?

 - b. If not, what made it difficult to do so?

3. How was the program perceived among staff?

4. Did staff complete their assigned tasks?
 - a. If not, why not?

5. What topics or activities were planned but not delivered?
 - a. What happened that these were not accomplished?

6. Who was missing that you had hoped to have participated in the program?
7. What explanations can you give for any discrepancy between the planned and actual participation?
8. Did you feel the program was beneficial for the parents who participated in it?
9. Have you noticed any changes in the program participants?
 - a. If so, what kind of changes?
10. In what ways do you think the program could be improved?

APPENDIX H

Follow Up Parent Survey

Date: _____

1. *What, if anything, have you learned about your own relationship with your parents and how it affects the way you interact with your children?*

2. *Did group discussions help you learn anything about how the separation and/or reunification from your children has affected your relationship with them? If so, what did you learn?*

3. *Did group discussions help you think about the emotional connection you have with your children? How so?*

4. *What skills or ideas did you learn from the group that can improve your relationship/bond with your children?*

5. *What did you learn in the group about play?*

6. *Have you considered using any of the play skills from the group in interactions with your children? If so, which skills would you use and why? If not, why not?*

7. *What is one play activity that you would consider doing with your child?*

8. *What skills or ideas did you learn from the group that can help with disciplining your child?*

9. *Have you noticed any differences in the relationship with your child(ren) since participating in this group? If so, what are they?*
10. *What did you like about the group?*
11. *What did you dislike about the group?*
12. *What would you change about the group?*

APPENDIX I

Group Leader Interview Protocol

1. How do you feel the group went?
2. What were some of the themes that came out in the group?
3. How was group attendance?
4. What ways did you attempt to improve attendance?
5. Were parents able to identify and articulate how their own parenting history has affected the way they parent their children?
6. Were all participants able to identify at least one way in which their mental health concerns interfered with their parenting?
7. Were the participants able to define emotional connection?
8. Were the parents able to identify ways they were able to connect emotionally with their children?
 - a. Were they able to identify ways that they struggled to connect with their children?
9. Were parents able to identify at least one way that they could improve the emotional connection with their children?
 - a. What were some of the techniques they came up with?
 - b. Were they able to come up with these ideas on their own?
10. Do you have any suggestions for ways to improve the group?

APPENDIX J

Attachment Based Parenting Group Manual

* Veronique Lee, MA

The Graduate School of Applied and Professional Psychology, Rutgers, the State
University of New Jersey

Outline for Group 1

Materials Needed:

- Box of pens
- Parent Survey
- Copies of schedule

I. Introduction

- a. Hello everyone... I'm _____ and I will be running the parenting group for you all. I am hoping that the group will provide you with an opportunity to discuss any issues you might have with parenting and also that you will have the chance to learn some new skills and ways to improve your relationship with your children.
- b. Overview of session:
 - i. Today I'm going to have everyone go around and introduce themselves,
 - ii. Then I'll explain a little more about the group.
 - iii. We'll talk about the group rules.
 - iv. I will have you all fill out a brief survey,
 - v. If we have time then we will begin our discussion..

II. Have everyone introduce themselves and give a reason for why they are interested in attending parenting group

- a. I'd like to start off by having everyone go around the room and introduce themselves
- b. Can you each tell me a little something about yourself, what makes you interested in the parenting group and one thing you hope to get out of the group
- c. Tell me a bit about your children? (can be asked after everyone goes around the group)

III. Explain group

- a. Purpose of the group: So I wanted to talk a little more about the group. The purpose of the group is to give you a place to talk about your struggles with parenting. Some of the things we will do in here are:
 - i. I hope to have discussions with you all about your time away from your children. What that was like for you and what it was like getting them back.
 - ii. I'd also like for us to have a chance to talk about your own childhoods ... I was hoping mainly to talk about your memories of how you were parented, what that was like for you, what kind of messages you got and how you think that affects how you interact with your kids. I think it's important that we talk about this because it will hopefully help you see some of the ways your past might influence how you are functioning now with your children...

I think it's easy for people to forget or not notice how things their parents or caregivers did affects us and how it affects the way you parent. So I hope to have a lot of opportunity for discussion.

- iii. I also hope for us to talk about what your relationship is like with your kids, and all discuss little things we can do to improve that relationship. We will talk a bit about how you interact with your kids, how you handle your children's feelings and things like that.
- iv. We will also talk a bit about child development
- v. discipline
- vi. Are there any questions?

b. Logistics

- i. As I mentioned before we will meet once a week for 12 weeks. We will meet down here every Tuesday from 4-5 (hand out schedule again)
- ii. Will receive a certificate upon completion of the 12 weeks.
- iii. The group will hopefully involve lots of discussion and activities because I don't want to stand up here lecturing you the whole time. I'm sure it would be boring for you all to hear me running my mouth for a whole hour and I don't like the sound of my voice enough to want to do that. So I encourage you to participate in the discussions.
- iv. Homework: There are times when I will suggest that you practice what we talk about in here with your kids, so you might have a bit of homework (don't worry it should be fun homework)
- v. There will also be handouts for you all throughout the group... so next week when we meet I am going to bring you all folders to keep the handouts in. So I expect that you all will bring the folders to group with you each week, so that you can keep track of the material.
- vi. Are there any questions?

IV. Group Rules

- a. Most of you have been in groups before, so I'm sure you are aware that there are group rules. I want to talk to you a bit about what the rules are. I have a few rules that I have for groups I run and will tell you what they are, but first I want your feedback regarding other rules that might be important for our group. I'm going to write down your suggestions for rules and type them up and bring a copy of the rules for each of you next week.
- b. Do you have any ideas for group rules?
- c. Rule 1: Respect yourself and others in the group
- d. Rule 2: Don't interrupt or talk when others are talking
- e. Rule 3: Avoid putting yourself down

- f. Rule 4: Be willing to give positive and negative feedback to others in respectful ways
- g. Rule 5: Be willing to accept feedback from others without becoming verbally or physically aggressive/defensive
- h. Rule 6: Maintain confidentiality outside of the group: meaning what is said here stays in here. Please don't talk about comments made in the group to others who are not in the group
- i. Attendance: Because of the amount of material presented in each session, you may not miss more than 3 of the 12 sessions.

V. Survey

- a. Hand out survey and explain what it is
- b. questions about the survey?

Parent questionnaire

Name: _____

Date: _____

Introduction: This is a brief questionnaire meant to help me get to know you better. Please answer the questions to the best of your ability. Your answers to these questions will help me understand what areas you need help with and what other information I should include in the group.

13. Please list 5 words to describe your relationship with your children.
14. Please list one thing you would like to change about your relationship with your child.
15. Please list one good thing about your relationship with your child.
16. What is it like for you when your children are upset?
17. How do you deal with your children when they are upset?
18. How often do you hug and kiss your children?

19. How often do you play with your children?

20. What kinds of activities do you and your children do together?

21. What is it like to play with your kids?

22. What do you do when your children misbehave?

23. What is one thing you are really good at in terms of parenting?

24. What is one thing you still need help with in terms of parenting?

Outline for Group 2

Materials Needed:

- Box of pens
- Completed Parent Surveys to return to parents
- Written group rules
- Folders
- Attendance sheet
- snacks

I. Group check in

- c. Any questions or reactions re: last week's group?
- d. Any concerns you want to address today?
- e. Overview of session:
 - i. Review what discussed last week
 - ii. Mention folders and hand them out
 - iii. Will discuss questionnaires completed last week
 - iv. Begin our discussion re: reunification
- 8. Review of questionnaire
 - a. Hand out folders
 - b. Give them time to review the questionnaire
 - c. How was it for you to complete the questionnaire? I know some of you had difficulties... can you talk a little about what those were?
 - d. Have them share responses... have them discuss as a group any issues it brings up for them... can mention comments made by other group members at the end of last week's session that not everyone heard
- 9. Discussion: Today I thought we could talk a bit about your separation from your children and what it was like getting them back. Is that something you would be ok with?
 - a. How long were you separated from your children?
 - b. Who were your children with? What steps did you take to get your children back?
 - c. What did you imagine it would be like to get your children back?
 - d. How did you feel while going through the process of getting your kids back?
 - e. What was it like once you had your children back?
 - f. What have some of the challenges been to having your children back?
 - g. What are some of the good things that have come out of having your children back?

Outline for Group 3 & 4

Materials Needed:

- Attendance sheet
- snacks

- I. Group check in
 - a. Any questions or reactions re: last week's group?
 - b. Any concerns you want to address today?
 - c. Overview of session:
 - i. Review what discussed last week
 - ii. Begin our discussion about family history

- II. Other discussion questions re: ways in which their past history of trauma, abuse and dysfunctional relationships with their own caregivers, affects their interactions with their children

Discussion Questions (from Adult Attachment Interview, Main, M. 1984)

1. What was your relationship like with your caregivers as a young child?
2. When you were upset as a child, what would you do?
3. What is the first time you remember being separated from your parents?
4. Did you ever feel rejected as a young child?
5. Were your parents ever threatening with you in any way?
6. How do you think your experiences with your parents have affected your adult personality?
7. Why do you think your parents behaved as they did during your childhood?
8. How do you respond now, when you separate from your child/children?
9. If you had three wishes for your child twenty years from now, what would they be?
10. Is there any particular thing you feel you learned from your own childhood experiences?
11. What would you hope your child might have learned from his/her experiences of being parented by you?

Outline for group 5: Perspective taking/understanding your child's emotions

Materials needed:

Snacks

Pens

Paper

Our Most Recent Argument Questionnaire

Homework Assignment

- III. Group check in
 - a. Any questions or reactions re: last week's group?
 - b. Any concerns you want to address today?
 - c. Overview of session:
 - i. Review what discussed last week
- IV. Activities
 - a. Activity 1: I would like you each to pick one of your children and write a description of them... we will go around the group and talk about the descriptions. I will then ask you all for examples from everyday life that fit the description.
 - i. *Questions to ask parents:* What do you think makes him behave this way? In your example what was he/she thinking and feeling? What were you thinking and feeling? Where do you think your feelings were coming from? (want to assess how they view their children, if they have insight to their children's behavior, and also where their attributions come from).
 - b. Activity 2: Perspective taking task
 - i. Handout: Our Most Recent Argument Questionnaire
 - ii. Please complete the following questionnaire and we will share our responses with the group.
- V. Homework: Go home and discuss with your child at least one autobiographical story about a specific event in which he felt happy, mad, scared or sad. Please write down briefly what the experience was like for you so that we can talk about it next time.

Our most recent argument

Directions: Please try to answer these questions from the point of view of your child during your last argument:

1. What was he or she thinking?

2. What was she feeling?

3. Did he or she feel that you understood him or her?

4. How would (s)he describe you at that moment (what did your behavior seem like to her or him?)

5. Did you feel understood by him or her?

6. What might you have done to make yourself better understood?

*Stosny, S. 1995. Treating attachment abuse: A compassionate approach. Springer Publishing Company, Inc. NY, NY

Homework assignment #1: Talking to your child about feelings

Directions: Before the next group discuss with your child at least one story about a specific event in which he/she felt happy, mad, scared or sad. Please write down briefly what the experience was like for you so that we can talk about it next time.

Outline for group 6: Perspective taking/understanding your child's emotions

Materials needed:

Snacks

Pens

Kids and Stress Handout

I. Group check in

- a. Any questions or reactions re: last week's group?
- b. Any concerns you want to address today?
- c. Overview of session

II. Review Homework Assignment

- a. Where you able to complete the assignment?
 - i. If not, why not?
- b. What was it like to do this activity with your child?
- c. How did he/she respond?
- d. How did you feel?
- e. How can you make this a regular occurrence?

III. Discussion questions:

- a. Overall do you feel that you understand your children's behavior and why they do the things they do?
- b. Can you give an example of a situation where you understood them?
- c. In that situation what were they thinking/feeling?
- d. Can you give an example of a situation where you did not understand them?
- e. Looking back now, what do you think was going on with them? What were they thinking/feeling?
- f. Do you talk to your children about feelings? If so, what are those conversations like? If not why not?
- g. What types of things have you noticed make your children upset? When they are upset what do you do?
- h. Review circle of repair handout --- discuss each section of the circle.
- i. Review Kids and Stress handout if have time

Outline for session 7: Play and the parent-child relationship

Materials Needed:

Snacks

- I. Group check in
 - a. Any questions or reactions re: last week's group?
 - b. Any concerns you want to address today?

- II. Rationale for playing with your children
 - a. *For the group leader:* Play therapy enables children to feel relaxed and more playful it is a very effective way for children to make advances in their development and increase their sense of well-being. It is also a useful tool that enables children to communicate and share a range of emotions with receptive adults, including incompletely processed traumatic and/or abusive experiences. Play is able to facilitate the expression of overwhelming emotion because it is easily accomplished non-verbally, which allows young children to express that which they do not have words for. This makes play an ideal way for caregivers to understand their children's emotional lives. By playing out dysfunctional as well as healthy adult-child relationships, children are able to develop stronger and more adaptive attachments to their caregivers

 - b. *For the parents:* Today we are going to talk about playing with your children... Over the next few weeks we will learn a specific way to play with children that helps them express their emotions and improve the bond between the two of you. The type of play we will discuss is what is typically called play therapy.
 - i. Teaches you the kinds of skills that play therapists use with children to build a good relationship with them and help them feel safe and calm
 - ii. Teaches you how to communicate with preschoolers with limited attention spans
 - iii. Teaches ways to teach your child without frustration for either of you
 - iv. improves your child's self-esteem
 - v. Improves your child's social skills like sharing, which children need to get along with other children and have friends
 - vi. Results a secure warm relationship between you and your child (which often gets strained with oppositional children).
 - c. Any questions?

- III. Discussion Questions
 - a. Do you play with your children?
 - b. What types of things do you do when you play?
 - c. What is it like to when you play with your kids?

- d. How do you think your children feel when you play together?
- e. How do you feel when you play with your children?

Outline for Session 8: Play and the parent-child relationship

Materials Needed:

Snacks

Toys

Do's and Don'ts handout

Appropriate toys handout

- I. Group check in
 - a. Any questions or reactions re: last week's group?
 - b. Any concerns you want to address today?

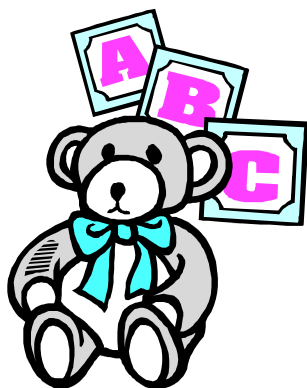
- II. PCIT materials... explain the structure of the play therapy to parents. "The rules that I will be describing are to be used during a daily 5 minute special play period at home. I don't expect that you or anyone would be able to keep up this high-quality, condensed therapeutic time for extended periods each day. In fact, I find that parents who try to spend longer than five minutes actually burn-out on play therapy because it takes so much energy. I don't want that to happen to you. So, the key to making play therapy work is to do a little bit consistently everyday, rather than doing it irregularly but for longer periods of time.
 - a. Basic rule is to follow your child's lead, like play therapists do

- III. PCIT rules: Things to avoid (hand out the Don't and Do Skills handout to parents)
 - a. The first rule is to avoid commands
 - i. Commands take over the lead of the play
 - b. Avoid questions
 - i. questions take over the lead of the conversation
 - c. Avoid Criticism
 - i. Criticism points out mistakes rather than providing correction
 - ii. Criticism lowers a child's self-esteem
 - iii. Criticism creates a negative interaction
 - d. Next we'll talk about what to DO --- the skills you want to use during the "special play time.

- IV. PCIT rules: Things to do
 - a. Praise your child's appropriate behavior
 - b. Reflection – repeat or paraphrase what your child says
 - c. Imitate appropriate play
 - i. Imitation means doing the same thing your child is doing
 - ii. Helps you play right at your child's developmental level
 - d. Describe appropriate behavior
 - i. State exactly what your child is doing
 - ii. Allows your child to lead

- iii. Lets your child know you're interested and paying attention to him/her
 - e. Be Enthusiastic!
 - i. Let your voice show excitement about your child's appropriate behavior
 - ii. Increases the warmth of your play
- V. Do roleplays... role play one with a parent and then have them split into twos and practice the skills themselves.
 - a. After the role plays have them talk about the experience...
 - i. What was it like for you?
 - ii. What are some of your reactions?
 - iii. Do you think you could do this with your kids?
 - iv. What would make it easier for you to do this with your children?
 - v. What would make it difficult to do with your children?
- VI. Homework assignment: begin the special play time at home... for parents who see their children everyday they should do it everyday... for others they can do it during visits with their children.

For the group leaders: If parents seem resistant to it try to help them do some perspective taking. E.g. "imagine if you had a chance to have special time with your parents when you were a child. A time when your parent focused totally on you with no distractions; no phones ringing, no arguments with your siblings, no focusing on their problems or their needs etc... imagine if you had 5 minutes a day with your parent that was all about you, with no criticism, no yelling, no making you feel small ... how would that have felt for you? Now think about how your child will feel when you give them this gift of having special time with you."



Suggested Toys for CDI

Creative, constructive toys like:

Building Blocks

Legos

Tinker Toys

Magnetic Blocks

Lincoln Logs

Constructo-Straws

Mr. Potato Head

Crayons and Paper

Chalkboard and Colored Chalk

Erector Set

Toys to Avoid During CDI

- Ones that encourage rough play, like:
 - bats, balls, boxing gloves, punching bag
- Ones that lead to aggressive play, like:
 - Toy guns, toy swords, tow cowboys and Indians, super-hero figures
- Ones that could get out of hand and require limit setting, like:
 - Paints, markers, bubbles, scissors, play dough, hammer
- Ones that have pre-set rules, like:
 - Board games, card games
- Ones that discourage conversation, like:
 - Books, video games
- Ones that lead to parent or child imagining they are someone else, like:
 - Puppets, costumes

* Eyeberg, S.M., 1999

Outline for Session 9: Play and the parent-child relationship

Materials Needed:

Snacks

Toys

Do's and Don'ts handout

Appropriate toys handout

- I. Group check in
 - a. Any questions or reactions re: last week's group?
 - b. Any concerns you want to address today?
 - c. Overview of session

- II. Review Homework Assignment
 - a. Where you able to complete the assignment?
 - i. If not, why not?
 - b. What was it like to do this activity with your child?
 - c. How did he/she respond?
 - d. How did you feel?
 - e. How can you make this a regular occurrence?

- III. Review rules of PCIT
 - a. Do's
 - b. Don'ts

- IV. Continue with roleplays
 - a. Have parents break up into groups of twos and practice PCIT skills.
 - b. Provide each dyad with feedback and encouragement

- V. Homework assignment
 - a. Continue the special play time at home... for parents who see their children everyday they should do it everyday... for others they can do it during visits with their children.

Outline for group 10: Discipline Skills

Materials Needed

- Snacks
- Attachment Compassion Scale

I. Group check in

- f. Any questions or reactions re: last week's group?
- g. Any concerns you want to address today?
- h. Homework ... Did you all try to do the homework assignment? If so, how did it go? If not, why not?
- i. Overview of session:
 - i. Review what discussed last week

II. Discipline Discussion Questions

- a. What comes to mind when I say the word discipline?
- b. How have you handled discipline in the past?
- c. Are there specific areas that you feel you need to work on?
- d. Do you feel that you get angry when your children misbehave?
 - i. If so, how does that affect you and how you interact with your children? How does it affect them?

III. Activity:

- a. Hand out attachment compassion scale and have them talk about it
 - i. Please complete this handout
 - ii. When you are all done we will discuss it

The Attachment Compassion Scale

Please answer the following questions with the number that most accurately describes your impressions.

- 5 Strongly agree
- 4 Agree
- 3 Unsure
- 2 Disagree
- 1 Strongly disagree

When I am very angry at my child, and I think about his or her point of view or how he or she is feeling:

- a. I feel angrier. _____
- b. I feel kinder toward her. _____
- c. I feel warmer toward her. _____
- d. I feel furious. _____
- e. I don't care about her point of view, at least not until I cool down. _____
- f. I feel more patient. _____
- g. I feel like I should give her support and sympathy. _____
- h. I feel like I should apologize for hurting his or her feelings. _____
- i. I feel charitable, forgiving. _____
- j. I find that I can't think about what she's feeling, until I cool down. _____

*Stosny, S. 1995. Treating attachment abuse: A compassionate approach. Springer Publishing Company, Inc. NY, NY

Outline for group 11: Discipline Skills- setting limits/managing your anger

Materials Needed:

Snacks

Handouts

- Parents are Models for their children handout
- What can you do when you're angry? Handout
- Effective commands handout
- How to create labeled praise handout
- Using a time out room in your home
- Setting up house rules
- Other discipline tools handout

- I. Group check in
 - a. Any questions or reactions re: last week's group?
 - b. Any concerns you want to address today?
 - c. Homework ... Have you all continued with the special play time activities? If so, how did it go? If not, why not?
 - d. Overview of session:
 - Review what discussed last week
- II. Managing your anger
 - a. We discussed this a bit last week, but I wanted to take the time to explore it more. Lots of times when parents are angry, they do not interact in the best way with their children. Do you find this true for you?
 - b. Review: Parents are models for their children handout
 - c. Review: What can you do when you're angry handout.
- III. Discipline skills
 - a. Giving commands
 1. Effective commands handout
 2. Commands should be stated positively
 3. Commands should be done one at a time
 4. Commands should be specific
 5. Commands should be age appropriate
 6. Commands should be given politely and respectfully
 7. Commands should be explained before they are stated, or after they are obeyed
 8. Roleplay--- have parents role play giving commands, can do it in groups of two or with the group leader
 - b. Giving praise
 1. Labeled praise handout
 2. Roleplay- have parents practice this skill
- IV. Time out
 - a. Using a time out room in your house
 - b. Discuss the idea of time outs
 1. have you used this skill before?

2. How has it worked?
3. Role play of time out procedures.

V. Review other handouts if there is time

Outline for session 12: Wrap up

Materials needed:

Snacks

Certificates

Group folders

Follow up parent questionnaire

- I. Group Check in
- II. Discipline
 - i. Continue with discipline discussions/handouts if ran out of time in last session
- III. Review of group
 - i. Handout certificates
- IV. Have parents complete follow up parent questionnaire

Parent questionnaire

Date: _____

13. *What, if anything, have you learned about your own relationship with your parents and how it affects the way you interact with your children?*
14. *Did group discussions help you learn anything about how the separation and/or reunification from your children has affected your relationship with them? If so, what did you learn?*
15. *Did group discussions help you think about the emotional connection you have with your children? How so?*
16. *What skills or ideas did you learn from the group that can improve your relationship/bond with your children?*
17. *What did you learn in the group about play?*
18. *Have you considered using any of the play skills from the group in interactions with your children? If so, which skills would you use and why? If not, why not?*

19. *What is one play activity that you would consider doing with your child?*
20. *What skills or ideas did you learn from the group that can help with disciplining your child?*
21. *Have you noticed any differences in the relationship with your child(ren) since participating in this group? If so, what are they?*
22. *What did you like about the group?*
23. *What did you dislike about the group?*
24. *What would you change about the group?*