

RESEARCH INTO PRACTICE/PRACTICE INTO RESEARCH

Home Visiting Family Therapy for Children at Risk

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Home visiting has a long history in the areas of health and welfare (Baldock, 1990: 121). Early intervention through home visiting programs has been found effective in preventing abuse and neglect in many countries including the USA (Olds, 1992), Ireland (Johnson, 1993) and Europe (Cox, 1993). The success of these programs lay in their effectiveness in reducing social isolation, improving parenting skills and enhancing self esteem. This paper reports on the role of family therapy in home-based early intervention for families with newborn infants.

THE PROJECT

In January 1996, the Royal Children's Hospital and District Health Service in Brisbane commenced the family CARE project. The project aimed to assess the efficacy of a home based support intervention for families with newborns in improving a range of outcomes for the child, the mother and the family. The project recruited mothers from the public wards of a maternity hospital in the immediate postnatal period. Inclusion in the project was on the basis of family vulnerability factors (sole parenthood, domestic violence, parental abuse in childhood, ambivalence toward the newborn, social isolation, poverty, financial stress, parental drug and alcohol abuse, parental psychiatric history) revealed by the mother in a self report questionnaire developed and validated prior to the inception of the project. One hundred and eighty-one families were enrolled in the project and randomly allocated to either the intervention group (90 families) or the comparison group (91 families).

The intervention was based on home visiting primarily by child health nurses, who were supported by a team to help address the particular needs of individual families. The team consisted of child health nurses, a social worker (eighteen hrs/wk), a parent aide co-ordin-

ator, and a community pediatrician; case conferencing was held weekly. A structured program of child health nurse home visiting occurred with each of the intervention families: weekly between two and six weeks, fortnightly until three months and thence monthly until six months. The intervention was focused on development of a trusting relationship with the family, anticipatory guidance for the expected problems of infancy (irritability, feeding, sleeping), promoting well child health care (breast feeding, immunisation etc.), empowering parents to make decisions in the best interests of themselves and their children, facilitating access to available community resources, and celebration of success at every visit by a professional involved in the team.

In this project, any one or all of the family members were seen by the team. This was at the discretion of the individuals and/or the entire family. In some cases, mothers were seen by themselves, where in others, violent partners or adolescent children were involved in the sessions. The team strongly held the view that everyone had something of value to contribute, whether it were one of the team members or a marginalised partner.

At various times depending on the need, some control of the social work visit would be taken if it was deemed necessary for goal achievement; for example, a particular family member would be invited to attend the next session. Families were warned of this possibility at the initial visit. In some cases of domestic violence where it was not always safe for staff to home visit, contact was made at another venue of the client's choice, such as a park or shopping centre. Violent partners were seen at home only if the safety of the worker could be assured. If this was not possible, they were seen in the office. Some authors have argued that home visiting is

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an unprofessional method of service provision and an invasion of client's privacy (Bloom, 1973: 67-75). It was our experience that the clients found home visiting to be empowering, for they were 'in control'.

Clients would be referred to the social worker and community pediatrician when the nurse felt it was appropriate. All work undertaken with the social worker involved a contract. As soon as the set goals were met, social work contact was formally terminated. However, informal contact was maintained with clients via the telephone should they feel the need to discuss an issue. All of the team members and clients would be working together on the latter's chosen goal. All aspects of a client's progress, from contract to termination, would then be discussed at case conference, even if only the nurse was involved. An independent researcher assessed an array of child and family outcomes within the home at inception, six weeks, four months and seven months.

The nurses would support the social worker's efforts by commenting on changes they had noticed in the client, thereby continuing the 'rippling effect' of the therapy undertaken by the social worker. The nurses were not expected to act as therapists. Similarly if the social worker noticed clients' progress on issues the nurses were addressing, (breastfeeding, bonding, etc.) she would briefly comment. The pediatrician, who would see each baby on a regular basis, was also encouraging of changes the client was making. In short, the entire team focused on noticing the smallest changes, highlighting these so they became newsworthy and helping the client to notice them. This solution-focused approach permeated the team's relationship with every client. To assist clients to acknowledge their achievements, reduce dependency and thus shorten the total time a client spent with the social worker, letters, awards and personalised stories would be created. The stories were based on issues raised in the counselling sessions and foregrounded the client's strengths, capacity to overcome the problem, and instances when they had 'beaten the problem'.

The stories were developed when the clients had already achieved many positive changes. In some cases when families were unable to see change, a story written by the team social worker about their successes enabled them to appreciate their innate wisdom. This then became concrete evidence, albeit on paper, of positive change. The nurses also used photographs for this same purpose. The team believed that once the client had addressed many of the unresolved issues in their lives, there would be benefits in other areas, for example, a mother who had resolved her marital issues would be freer to attend to her child. The team saw many examples of this.

RESULTS

Early results from this project are very encouraging. At six weeks, four months and seven months significant positive differences were found for measures of mother-infant attachment, sense of parenting com-

petence and satisfaction, maternal mood, quality of partnership and satisfaction with the community child health service.

DISCUSSION

The importance of home visiting cannot be overstated. Woods (1988: 211) noted that for families with limited resources, the stress caused by travelling to an office may work against any benefit derived from the therapy. Had the home visiting option not been available, the women seen by this team, who were often victims of domestic violence and/or child abuse, probably would not have sought help until they or their child had come to the attention of the authorities.

The team had to be flexible, because in home visiting the clients can terminate the interview whenever they want, and play their everyday roles without the fuss and preparation necessitated by an office interview (Woods, 1988: 212). It was only very occasionally, however, that project families kept their television on, in which cases the difficulty this caused the staff member would be discussed. Clients were able to choose whether they wanted to continue the session or discuss the issue on another day. The issue of boundaries rarely became problematic as nearly all of the families were extremely grateful for the intervention. An exception to this was a family which was reported to the authorities for abuse, refused to talk to staff and withdrew from the project.

Another benefit of home visiting was that the family had the opportunity to trial the suggested strategies immediately and to receive coaching, particularly in work with parents and their non school aged children. This capacity for coaching minimised the risk of failure and enhanced the client's belief that change was possible.

Unlike most new parents, the intervention group did not have to leave home to get their baby weighed, obtain breast feeding or immunisation information, or seek relationship or personal counselling. The families were very appreciative of having professionals visiting them at home (many likened it to winning the lottery!) Both Hobbs (1965: 176) and Trotter (1997: 23) have acknowledged the 'gift' or 'reward' potential of home visiting.

Some authors (Furlong, 1989: 217) have raised a concern over the lack of attention given to home visiting by family therapists. Others (Chapman, 1997: 47) have suggested that work with the more marginalised and neglected groups will become less frequent with contractual arrangements being currently preferred in the public sector. Family Therapy is rarely a component of contracts. However, this form of therapy could be offered in the home if social workers were willing and their employers were supportive. There are many benefits not just for the clients but also the organisation. In this project, we found family therapy in the home to be time-efficient and effective.

CASE EXAMPLE

Phillipa was a 30 year old woman who was unhappily married and had two children, one aged three years and the other a newborn. There were financial problems, and she was isolated. Phillipa had experienced all forms of abuse and neglect over a long period of time at the hands of her mother, six stepfathers and one brother. She also suffered from a hereditary life threatening disease from which she developed tumours which could kill her. Her mother and sister had both died from tumours. Phillipa was referred to the social worker because she was concerned about her parenting and fearful that she would abuse her children.

During our first contact, Phillipa explained that she often experienced great difficulty speaking to strangers, particularly when she was anxious. For example, Phillipa initially was unable to leave a message on an answering machine. She was also very distrustful of social workers due to past experiences. She rarely left the house for fear that someone might harm her children. If Phillipa had not been home visited, it is doubtful that she would have received help until her children had actually been harmed. Phillipa was provided with the support of the entire team—whether that meant the nurse, parent aide, pediatrician or social worker. The therapy that was undertaken with the social worker during any particular week was mentioned by the nurse to assist in the change process. The social worker always sent a letter documenting the change. Awards and stories were also used for the same purpose.

Phillipa set herself four goals and these formed the basis of the contract: improve her parenting by addressing abuse issues, display more self respect and self-love by losing weight, reduce her anxiety, and increase her self confidence as evidenced by freer flowing speech. At the time that the contract was established, indicators of slight success and ultimate achievements were established. These then formed the basis of termination as they became a constant reference point, ensuring that we were on the right track and that progress was being made. In all sessions, Phillipa and/or her husband chose the topic for discussion (they were in control and being treated respectfully) possibly for the first time ever. Many issues were discussed, including particular incidents of abuse, fears in her life, relationship issues and parenting difficulties. Sometimes, this process would be controlled by the social worker.

After five months of regular visitation, Phillipa had changed significantly. The social work sessions took the form of one hour a week for eight weeks; when Phillipa felt she was making some progress, she requested fortnightly visits. The social worker agreed to this change and felt it was warranted. This reducing scale of regularity continued until all goals were achieved. Both the client and the social worker were comfortable with the termination. Phillipa had lost eight kilos in weight, had got herself a job, felt confi-

dent in her parenting, had placed one child in child care to give herself a break, and was rarely hesitant in her speech. She had also acquired an answering machine on which she left her own message. Some of the relationship issues remained unaddressed but the couple did not wish to discuss these. They were given names of services which they could contact should they be ready at some stage in the future. Phillipa was one of many clients who benefited under the home visiting programme in which the social worker utilised a family therapy approach and was supported by a creative team of risk takers.

CONCLUSION

Benefits of home visiting have been well documented, and policy makers need to consider the long-term and preventive advantages. This project has shown that a home based multidisciplinary approach to vulnerable families' needs is both acceptable and effective. The role of the family therapist social worker was integral to the success of this approach. If family therapists continue to work with the paying client only and if therapists and health workers are not willing to home visit, then it could well be argued that the most needy will not be served, and that society will be further contributing to the cycles of poverty and abuse it has helped to create.

The primary author is no longer involved in the Family CARE Project and has returned to her community position. She now receives referrals from the child health clinics. However, home visiting family therapy continues to be offered. The referring nurse is encouraged to notice all changes that the client is making and to comment on these. The practice of using letters, stories and awards continues and remains effective. This approach is still helping clients in their efforts to make a difference in their lives. It could be offered through any agency if staff were willing to take the risk of offering family therapy at a client's home.

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Ecologically Correct Research

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After the birth of our third child I shared a ride in a lift with a young Italian couple whom I had seen on the ward, and who were on their way home from the hospital with their twin babies. The twins were awake most of the night, an ever-increasing troop of extended family and friends had visited en masse during the day, the mother was breast feeding both babies, and each day I saw her, she appeared increasingly exhausted. In the 30 second trip in the lift, her husband berated her repeatedly for various trivial sins. I resisted the urge to offer them all sorts of help, but it terrified me that they were returning home with such pressures, and with a pattern of unhelpful interactions between them. They had some family support, however my sense was that the family were unresponsive to the parents' pressing needs, and were caught up with their own pride. Considering the families in the Huston and Armstrong study, and adding poverty, isolation, violence, and contextual and psychological problems to the picture, it became clear to me why the type of preventative study undertaken by Cathie Huston and Ken Armstrong is so important. The research undertaken in this study is not rarified or ground breaking. It does not claim elaborate theory in its inspiration and certainly does not describe itself as postmodern. Nevertheless the study and the intervention exemplifies some important issues for clinicians, and has several distinctive features.

The defining feature of Huston and Armstrong's study is that the intervention is based in the homes or immediate surroundings of the families. This contextual factor would have maximised the comfort level for these families, and probably strengthened the therapeutic alliance.

The second distinctive feature is the inclusion in the sessions of whoever was available, and the adoption of flexible rules for the intervention with each family. As the families had a variety of economic, social and relationship difficulties, it made sense to create interventions tailored to the realities of the families' particular situations. In terms of the research design, this factor in the treatment makes it difficult to see the intervention group as a single entity. Rather there were some differences in the intervention across families due to the differences in membership in the therapy. More importantly however, both the intervention and the research were culturally appropriate, and could be considered 'ecologically valid', to use Bronfenbrenner's (1979) notion. This concept refers to the extent which methods and findings accurately reflect the group in question, based on the psychosocial context and constraints.

The third feature of Huston and Armstrong's study is the emphasis laid by the workers on addressing the most

immediate physical and practical problems before moving onto other problems. Many therapies attempt to 'get to the heart of the problem', rather than dealing with what is presented first, an issue addressed by Haley (1987) in his advice on the management of the initial interview. The approach outlined by Huston and Armstrong reflects a sound emphasis on working towards small, achievable goals. Such an approach would have ensured that the family remained motivated.

The fourth feature was the use of clear boundaries. The nurses and social workers had distinct roles, which probably helped separate the practical issues of caring for the new child from the pre-existing or concurrent emotional and social problems experienced by the families. Fifth, the therapy was structured by the behavioural, observable goals identified by the family, and by clearly stated criteria for progress, which became the basis of the therapeutic contract. Therapy was discontinued when these goals were achieved.

Sixth, although the authors described the therapy as 'solution focused', their practice differs somewhat from the model developed by de Shazer (1985) or others in this genre. Rather, the therapists helped the families formulate clear goals based on the discussion of the problems, and then used narrative and other methods to encourage change. In the case study described, the client had fourteen sessions, which was probably long enough to address in some depth some of the issues raised. It would be important to know the average number of sessions of the intervention, but this case study implies that therapy was not 'one session wonder' therapy, but rather, therapy designed to address the multi-problem presentations. The authors reported that when discussing complex issues in the client's life in the therapy, 'Sometimes, this process would be controlled by the social worker'. Such comments imply that the descriptions of the intervention were not driven by dogma, but by the actual approach of the therapists.

The comparison of 90 families involved in the program and 90 controls increases the importance of the study. This is a large sample for a community based program, and as such would allow for some confidence in the results. Making provision for assessment at various points before, during and after therapy follows solid design principles of outcome research. The study measured different factors in the family functioning that would discriminate aspects of the change process, and would also identify the areas the intervention would affect most and least. Clearly only the bare bones of the results are described above, nevertheless this type of study would be appropriate and feasible for many organisations.

Lyman Wynne's (1988b) proposed criteria for the worth of research are: problems with high incidence, prevalence, severity, cost, public visibility; where the problems are insufficiently treated in other approaches, and where the therapy mode is acceptable and practical. On these criteria, the Huston and Armstrong study is very valuable. It also appears to be driven by sound therapeutic principles, and less by political or thera-

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peutic correctness, or by the naive quest for novelty that leads some approaches into disregarding the essential ingredients of therapeutic intervention. The approach of Wileman and Wileman (1995) addressed the treatment of relationship violence without the shackles of political/therapeutic orthodoxy, and found surprising, worthwhile results that contrasted with ideological and therapeutic rhetoric. Similarly, Huston and Armstrong's study could be said to be unfashionable, but represents a timely example of ecologically correct (rather than politically correct) therapy and research.

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