A family-based description of residential treatment

Alan Dwaine Demmitt
_Iowa State University_

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A family-based description of residential treatment

Demmitt, Alan Dwaine, Ph.D.

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A family-based description of residential treatment

by

Alan Dwaine Demmitt

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In Charge of Major Work

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Signature was redacted for privacy.

For the Graduate College

Iowa State University
Ames, Iowa

1994
A family-based description
of residential treatment

Alan Dwaine Demmitt

Major Professor: Harvey H. Joanning
Iowa State University

Children have been placed in residential treatment centers for over 300 years. Past research has examined this placement from the child's and/or from the worker's point of view, rather than from the family's perspective. This dissertation describes families' perceptions of Stratford Home's residential treatment process which emerged from moderately structured focus groups. The results suggest:

- Parents want to be more involved in making decisions and setting goals concerning their child.
- Special care is needed when two families are involved with one child.
- Family therapy is useful in dealing with family issues and family-staff conflicts.
- Regular communication is needed between the staff and the parents.
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CHAPTER 1
INTRODUCTION

In 1983, 19,215 children lived in residential treatment centers in the United States. By 1986 the number was 25,334, an increase of 32%. More than 30,000 children are expected to be placed in residential treatment facilities by 1995 (Select Committee on Children, Youth, and Families, 1990). As the population of residential treatment centers continues to rise, the debate over the efficiency and usefulness of such centers intensifies. Advocates for de-institutionalization argue for a reduction in the number of children in placement, whereas those providing residential services support the expansion of residential treatment facilities.

The experience of the families involved in residential treatment has been overlooked in the debate about the usefulness of residential treatment centers (Small, Kennedy, & Bender, 1991). In order to meet the needs of families and make intelligent decisions regarding residential treatment, the professionals involved in residential treatment need to understand and consider the needs of the families who are interacting with the residential facilities (Carman & Small, 1988). This qualitative study looks at the experience of families who have had a member placed in a residential treatment center for adolescents.
The families involved in this study have had children in residential treatment at Stratford Homes (a fictitious name). Stratford Homes is a private residential facility contracted by the state to provide long term residential treatment to adolescents. Stratford's program has been considered a medium to long-term treatment program, with treatment ranging from 6 months to 2 years.

Adolescents are placed at Stratford Homes by the state judicial system. The families of some adolescents supported the court's decision for placement, while other families viewed the placement strictly as a punishment, not recognizing any beneficial aspects. Families became involved in their adolescents' treatment program at different levels, ranging from highly involved to no contact. This study has described how the families experienced their adolescent's treatment at Stratford Homes. This information will be used by Stratford Homes to make their services more family-guided.

**Purpose of the Study**

The present study has sought to develop an initial ethnographic account of the experience of families with an adolescent in residential treatment at Stratford Homes. Designed as a mini-ethnography, the research has not documented or analyzed quantitative data. The content has
been limited to a discussion of the families' construction of its Stratford Homes experiences.

Stratford Homes resembles many residential treatment facilities in its treatment process. Individual, group, and family therapies are important components of the treatment process. In addition, the staff emphasizes socialization skills which enhance the adolescents' ability to work and live with others in a peaceful and productive manner.

This study has collected the experiences of families who have been involved in Stratford Homes' treatment process. The information will be fed back to the Stratford staff so that they may make their treatment process more family-guided. This information will also be useful to family therapists by providing information on how to work with, and in, residential facilities. In addition, this information will be relevant to other residential treatment facilities that use similar treatment methods.

Limitations of the Study

Issues which may have limited the transferability of the study are:

1. Informant families interviewed in the study were families who had an adolescent at Stratford Homes.
2. Only qualitative data were gathered and examined for the study.
3. Informant families interviewed in the study were predominately of the Caucasian race.

4. The epistemology, values, and beliefs of the researcher biased the researcher's perspective of the subjects. The researcher's biases which may have impacted this study include:
   
   A. The individual is the expert regarding his/her own experiences.
   
   B. Pathology exists in relationships, not in isolation. Thus, to effectively treat the adolescent, one must work with their pathological relationships.
   
   C. Change does not occur in isolation. Therefore, the most effective residential treatment includes the adolescent's family.

Assumptions of the Study

The methodology and research design carried these assumptions:

1. The informant families were representative of the families involved in Stratford Homes' residential treatment.

2. The focus of the study has generated new information about residential treatment.

3. The design of the study was deliberately subjective and qualitative in nature.
Questions Posed in the Study

The study addressed the following questions:

1. From the family's point of view, what has been helpful or not helpful about Stratford Homes' treatment process?
2. How, if at all, has the family felt it was a part of the treatment process?
3. In which of the following areas would the family have liked to have been involved?
   - Parent discussion groups
   - Parent education/training
   - Involvement in cottage life
   - The setting of goals
   - Phase promotions for the adolescent
   - Knowledge involved in phase promotion
   - Involvement in promotion process
4. From the family's point of view, what role has family therapy had in the treatment process?
5. From the family's point of view, how could the effectiveness of family therapy have been increased?
6. What advice have families for parents who are just beginning to work with Stratford Homes?
7. What advice have families for professionals who work with families at Stratford?
Summary

Chapter 1 presented the purpose and significance of the study for the field of human development and family studies. Chapter 2 contains a brief review of the literature. Chapter 3 has a description of the methodology used in the study. The results and conclusions have been provided in chapters 4 and 5.
CHAPTER 2
REVIEW OF RELATED LITERATURE

This section presents a summary of prior research in residential treatment, family therapy in residential treatment, outcome studies, models of residential treatment, qualitative research, and focus groups.

Residential Treatment

Treatment centers created exclusively for children have been a fairly recent development. Before the sixteenth century practically all of the care for children with problems labeled as emotional or behavioral problems has been done by their family, extended family, or friends. The only formal alternative for caring and providing for these children was the church (Wilson & Lyman, 1983).

The first public supported system of residential care for children were the alms houses established in England in the 1600's to care for destitute children (Mayer, Richman, & Balcerzak, 1977). Since the 1600s, two parallel systems for caring for children have existed. One system consisted of church-based facilities which primarily cared for dependent children and were privately funded. The other system involved
publicly-supported facilities which served disturbed and delinquent children as well as dependent children.

For the next 300 years, the practice of placing children in institutions grew throughout Europe and North America. As the need for care increased, the size of the institutions grew as well. As the institutions grew numerically, it became increasingly difficult to provide quality care for the children. Wide-spread abuses began to occur (Mayer et al., 1977). In the late 1800's and early 1900's the concept of children's rights began to emerge. This awareness resulted in a general dissatisfaction with the large institutional programs provided for children (Hopkirk, 1944). Residential care systems responded to this criticism by adopting a more home-like, or cottage, approach to care.

Often the act of placing an adolescent into residential treatment has created psychological turmoil for the child (Gispert, Wheeler, Marsh, & Davis, 1985). Being physically separated from the family can be painful for the adolescent. The placement process, be it voluntary or involuntary, may force the adolescent to cognitively deal with two conflicting beliefs: 1) My parents love me and care for me and 2) I am in placement and am not being cared for by my parents (Levine, 1988). Adolescents thus frequently experience treatment shock immediately after being placed in a residential facility (Levine, 1988). Treatment shock refers to the confusion
adolescents may experience as they move from a deprived home setting to the therapeutic and nurturing environment of a residential facility. This shock is manifested by the venting of hostility, withdrawal and/or isolation from caregivers, and speeches about unrealistic plans for the future.

Family Therapy in Residential Treatment

The goal of residential adolescent care has shifted from providing long term, substitute parenting of children to giving temporary, respite care combined with services designed to help restore and reunite families (Carlo, 1985; Garland, 1987). The shift in focus has changed the involvement of parents in residential therapy. Once parents were seen as a harmful influence and a problem to be endured. It was not until the 1950's that parents were viewed as a potential asset in the treatment of the child (Letulle, 1979; Magnus, 1974). Since the 1960's, parents have been judged less and have been separated from their adolescents less (Carlo, 1985).

Expanding the focus of treatment from the adolescent to the family has provided professionals the opportunity to view the adolescents' behavior in a more "natural" setting. According to Stewart (1984) and Carlo (1985), the participation of the family was a key factor in the child's functioning both during placement and after discharge. An individualized intrapsychic orientation emphasizing the
resident more than the family may have produced changes in the individual while he/she was in treatment, but often the adolescent reverted to previous behavior upon returning home (Carlo, 1985; DeSalvatore & Rosenman, 1986; Magnus, 1974). In response to this lack of permanent change, families have been included in the treatment process through family therapy (Robinson & Robinson, 1979).

Besides the pragmatic value of including the families in treatment, there has been a legal rationale as well. United States PL 96-272, the Adoption Assistance and Child Welfare Act of 1980, presented a national standard of child welfare which has mandated that children's services must have as goals the reunification, rehabilitation and remediation of separated families and their children (Carlo, 1985). To accommodate the new goals the professionals who work with children have adopted a theoretical perspective that places the family, instead of the child, as the focus of services.

Adopting this new theoretical perspective has had great implications for the way residents' parents are viewed and treated by agency staff. As Simmons, Gumpert and Rothman (1973) and Robinson and Robinson (1979) have suggested, the change in focus has required a change in treatment. "Family therapy provides conceptual models for understanding the systems within which people function and a set of techniques for restructuring those systems" (Biddle, 1978, p. 43). Thus,
family therapy has helped facilitate the change in focus from the adolescent to the whole family (Van Hagen, 1983).

Family therapy in residential treatment has had many uses. According to Koret (1973), family therapy was most useful at the child's admission to the facility. Family therapy provided a time for the family to see problems from a different perspective. Family therapy helped redefine the problem from a child problem to a family problem.

Family therapy has also been useful during crisis intervention. During a crisis the family was more open to change and to learning new approaches to old problems. In family therapy the therapist assisted the family in finding new solutions. Finally, Koret viewed family therapy as a means to help the family make the transition from having the child live outside of the home to living back in the home.

Family therapy has also impacted residential treatment in therapy with families broken by divorce (Weisfeld & Laser, 1977). Often the child entering a residential treatment facility from a divorced family has unresolved issues about the divorce. The child may have been uncertain about the reason for the divorce, and have trust issues that needed to be explored in relationship with the parents. There may have been ongoing issues between the parents about the child's placement. For example, the parents may have been unintentionally involving the child in their disagreements. A
parent may be using the child to get back at the other parent or one parent may have been blaming the child for the divorce. Family therapy has provided a context in residential treatment where the issues connected with the divorce can be discussed.

Family therapy has also used multifamily groups to treat families in residential treatment (Millard & McLagan, 1972). The approach has used combinations of children, parents, and other family members to create groups that discuss pertinent issues. Families have found multifamily groups helpful in providing a new perspective on a situation, reinforcing the idea that they are not alone, and learning new techniques for dealing with difficult situations.

Past and Needed Outcome Studies

Research on the outcome of residential treatment for adolescents has fallen behind research in related areas, such as developmental psycho pathology and outpatient treatment of emotionally or behaviorally disturbed children (Curry, 1991). Reasons for the lag have included a lack of money for longitudinal studies, a lack of research using comparison or control groups, and the difficulty of designing a methodologically consistent study (Quay, 1986). The difficulty has come from the impossibility of knowing what would have happened to a child if he/she had not been put into a treatment facility. Therefore, researchers have questioned,
what part of the change came from treatment and what part was due to adolescent maturation or the family's history (Lewis, Lewis, Shanod, Klatskin, & Osborne, 1980)?

Five major reviews of residential treatment have focused at least partially on the results, or outcome, of residential treatment. All five studies have called for research on families' experiences and involvement in the treatment process (Durkin & Durkin, 1975; Maluccio & Marlow, 1972; Quay, 1986; Whittaker & Pecora, 1984; Wilson & Lyman, 1983).

Because of the lack of research however, little information has been available about how the combination of child and family-centered treatment impacts the outcome of treatment (Wells, 1991). Family-centered treatment is treatment where the family, not the child, is the primary focus. Outcome information about family-centered treatment would have been useful in deciding if treatment could have been helpful. In addition, family-centered information would have been useful in determining what type of treatment facility would best meet the needs of the family and adolescent.

Professionals involved in the residential treatment of adolescents have been caught in a battle between the theoretical and the practical. Professionals are aware of the value of including the parents, but are not sure how to deal with problems of geographical distances and time constraints.
There is a need for research to bridge the gap between the theoretical notion of including the family and the reality of the current practice (Maluccio & Marlow, 1972). In addition, there has been little research which has focused on the role of parents in treatment as seen from their perspective; especially about what factors they see interfering with their consistent and meaningful participation (Soth, 1986).

Models of Residential Treatment

Psychoanalytic Models

Basic elements of the psychoanalytical model of residential treatment, as described by Bettelheim (1974), have included the isolation of children from their natural parents and the use of an analytical framework for all treatment interventions. This has emphasized the therapeutic importance of a treatment team consisting of psychiatrist, psychologist, and social worker, while de-emphasizing the importance of the on-line worker. Individual psychotherapy has been the primary focus of treatment in this approach. This model has been the standard for residential treatment programs until the advent of behaviorally-oriented programs in the 1960's.

Behavioral Models

Behaviorally-oriented residential treatment models have focused on the child's behavior rather than on inner
conflicts. Problem behaviors have been viewed as resulting from past learning experiences. To change the unwanted behavior, positive and negative consequences have been applied to achieve the desired effect. Treatment has been conducted by the on-line workers and has been viewed primarily as a learning process rather than a healing one (Browning & Stover, 1971).

Psycho-educational Models

The psycho-educational model has emphasized community involvement and short term treatment that encouraged contact between a child and the parents. Specially trained teachers have focused on re-educating the adolescent rather than treating the past (Hobbs, 1966).

Peer Culture Models

Peer culture models have relied on formal or informal group discussions as well as group control of privileges or rewards. Treatment has consisted of confrontation and feedback in the group discussions. Appropriate behavior has been reinforced with positive consequences. On-line staff have been involved in the confrontation and feedback between the adolescents. The effectiveness of the program has been derived from the interaction of the residents (Vorrath & Brendtro, 1974).
Overview of Stratford Homes

Since 1985 Stratford Homes' treatment model has consisted of four residential facilities located in a midwestern state. The State's Department of Human Services (DHS) has licensed the facilities as group foster homes. "Cottages" at each facility have served as homes for the adolescent residents. Four residential counselors and a social worker have staffed each cottage. The residential counselors have lived at the cottage and have been responsible for nurturing and taking care of the residents' physical needs. The social worker has served as treatment team leader of the cottage and as liaison between the residents and services outside of Stratford Homes. In addition, each campus has been staffed by a family therapist, recreation director, education coordinator, and a nurse.

The focus of treatment for each adolescent was determined by the goals stated in their treatment plan. Treatment plans have been established for each resident based upon the presenting problem, current needs, and family situation. The treatment plans have been reviewed and updated every 90 days at the child's quarterly staffing. The DHS required that the quarterly staffing were conducted and involved the child's DHS social worker or probation officer and a representative of Stratford Homes.

Before a child was placed at Stratford homes, there was usually a pre-visit. The pre-visit has been designed to
acquaint the family with Stratford's facilities, staff, rules, and expectations for family participation. Usually the pre-visit has been attended by the child's referring worker, the child, and the family. While a pre-visit has not been made mandatory, most families visit a campus before the child is placed.

Stratford has used a phase system to monitor the child's progress. At the orientation phase, the adolescent has acquainted him/herself with the rules and routines of cottage life. In phase 1, residents have focused on their individual behavior and the areas in which their lives need to be improved. Phase 2 has focused on the adolescent's interaction with their peers. Communication skills and techniques to avoid conflict and live with others in harmony have been developed in phase 2. In phase 3 the adolescent will have demonstrated leadership in the cottage by helping others monitor their behavior and by having set a positive example for his/her peers. Phase 4 will have prepared the adolescent for returning home. The resident has participated in more home visits and demonstrated an ability to make good choices on a day-to-day basis. Advancement from one phase to another has depended on the resident successfully completing certain written materials and on getting a "yes" vote from the cottage staff.
The family and child have been encouraged to maintain contact while the child has lived at Stratford Homes. The child will have learned to write his/her parents at least once a week. The family has also kept in contact through personal visits, although initially the child must wait 30 days before there can be any physical contact with the family. During the 30-day wait, contact has been limited to telephone calls and letters. After 30 days the family can visit the campus. After 60 days, the family can visit with the child away from the campus. After 90 days the family can have a visit with the child at home. The child has been allowed one overnight visit per month while in phase 1, two overnight visits per month in phase 2, three overnight visits per month in phase 3, and four overnight visits per month in phase 4. The child has been allowed to visit two weeks in the summer. Requests for a visit are submitted 10 days prior to the visit and are approved by the cottage staff. Stratford Homes have established rules for the child's behavior at home and parents have been expected to return a home visit evaluation form stating whether the child obeyed the rules, plus any additional comments.

Dave Castle, Ph.D., former director for family services for Stratford Homes, has outlined eight principles of change (1987) which have guided the treatment plans used with the adolescents.
1. Staff should encourage participation by the adolescents rather than demand absolute compliance.

2. Staff should emphasize the value of helping and caring for others rather than winning or losing at all costs.

3. What adults reinforce, adolescents will tend to make important in their lives. Start with the positive strengths of the child rather than reinforcing their weaknesses.

4. The maturing adolescent should be able to give and receive feedback and help from peers and adults.

5. A staff that has focused on the child's problems rather than on symptoms is less likely to become punitive and punishing. Concentrate on the motive behind the adolescent's behavior.

6. It is the staff's responsibility to create a climate where the adolescent feels as if they can succeed.

7. Having problems is acceptable. Not working on those problems is not acceptable.

8. Change is an inevitable process with identifiable stages.

**Qualitative Research**

For the last decade it has been recognized that there is a need for a research methodology that is consistent with systems theory (Atkinson, Heath, & Chenail, 1991; Durkin, 1987; Keeney & Morris, 1985; Newfield, Kuehl, Joanning &
Quinn, 1990) and also meets the needs of the researcher who is involved in process research (Greenberg & Pinsof, 1986).

Many quantitative researchers examining family therapy's impact on families have encountered difficulty because of the heterogeneity between families and between therapists. Although the traditional practice of using quantitative methodology has been helpful in testing hypotheses, it has not been as useful when the researcher is intent upon recording and learning a person's experience (Lincoln & Guba, 1985). Moon, Dillon, and Sprenkle (1990) have suggested that qualitative research designs may provide methods which would allow researchers to use a methodology consistent with systems theory.

The acceptance of and excitement surrounding qualitative research designs in family therapy has been evidenced in many aspects of the field. The Journal of Marital and Family Therapy, the official journal of the American Association for Marriage and Family Therapy has consistently published articles on the value and usefulness of qualitative research designs (Atkinson, Heath, & Chenail, 1991; Cavell & Snyder, 1991; Moon, Dillon, & Sprenkle, 1990; 1991). The American Association for Marriage and Family Therapy has offered a one day institute on qualitative research design at its last two national conventions. In addition, the Commission on Accreditation for the Marriage and Family Therapy Education
has approved the qualitative research design class as offered in marital and family therapy programs.

As the popularity and acceptance of qualitative research design has grown, so has the information available to the qualitative researcher. There has been an increase in the number of textbooks on qualitative research methodology and in the number of studies with a qualitative research design in educational journals (Lincoln & Guba, 1985; Strauss & Corbin, 1990).

A debate has developed among those who support qualitative research design which has revolved around the "messiness" of qualitative research designs. Moon, Dillon, and Sprenkle (1990) wrote:

Research is especially "messy" in a field like family therapy which is concerned with complex, systemic change in human beings. Qualitative research designs may provide a systematic scientific way of looking at therapy holistically, with all of its "messiness" intact.

(p. 364.)

On one end of the continuum are those who have worked to develop a rigorous set of criteria for conducting qualitative research. Professionals who stressed the need for rigorous methodology believed that by following established criterion for trustworthiness (Lincoln & Guba, 1985), the believability of the findings can be established (Guba, 1981; Lincoln &
Guba, 1985). On the other end of the continuum are professionals who think that using an established criterion does not necessarily increase the trustworthiness of the data. Walters (1990) wrote that the evidence has not supported the notion that the quality of an insight is dependent on the methodology used to generate it. Atkinson, Heath and Chenail (1991) went even further with the statement:

Researchers should be given the freedom to immerse themselves in unique experiences, follow their instincts and hunches, allow insights to arise, and then illustrate these insights vividly enough so that their colleagues and community members can understand them, try them out, and evaluate them for themselves. (p. 163)

This researcher has contended that these two positions are not mutually exclusive. This research project used the criteria for trustworthiness described by Lincoln and Guba (1985). Within the limits of criteria, the researcher used an emergent design. An emergent design has allowed the researcher the freedom to use the information gathered in preceding steps to influence the following steps of the project. In other words, the researcher has had the freedom to follow a hunch rather than be locked into a totally pre-set design.

At the heart of all research, quantitative and qualitative, are the questions:
• Truth value. How can one believe the findings presented?
• Applicability. Are the findings applicable to other contexts?
• Consistency. Would the same, or similar, findings be repeated if the research were conducted again?
• Neutrality. Are the findings an accurate description of the respondent?

Table 1 demonstrates how the different research paradigms respond to these questions.

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The qualitative methodology developed and implemented in this research project was based on the indicators of rigor described by Lincoln and Guba (1985). *Indicators of rigor* was the umbrella term that covered the concepts of credibility, dependability, confirmability, and transferability (Guba, 1981). *Credibility* focused on the congruence between what the informants described and what the researcher reported. *Dependability* focused on maintaining the integrity of the
research design and at the same time allowing for an emergent design. Confirmability focused on whether the data presented a good picture of what was being studied. Transferability focused on whether the findings from one context provided information about other contexts which may be similar (Brotherson & Goldstein, 1992). By conscientiously applying all of the indicators of rigor, the information gathered could be potentially richer, and more closely descriptive of the phenomenological experience of the informants involved in this study.

Qualitative methodology provided the best approach for the study of human interactions with all of its complexity (Moon, et al. 1990). This research project has been designed to gain an understanding of the family's experience of having a member in a residential treatment center for adolescents. A qualitative research design was selected because it enhanced the investigator's ability to understand the participant's experience regarding a specific life experience (Brotherson, 1990).

In conclusion, qualitative methodology has been the best approach for this project for three reasons. First, qualitative inquiry has explained the complex connections of human relationships and perceptions as they are constructed in the minds of people (Stainback & Stainback, 1984). Second, the qualitative paradigm has acknowledged that the inquirer
and informant have influenced each other (Brotherson & Goldstein, 1992; Patton, 1990). Third, in the qualitative paradigm truth has been seen as a matter of perspective rather than absolute and independent of the observer (Gergen, 1992).

**Focus Groups**

A focus group can be defined as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment. It is conducted with approximately seven to ten people by a skilled interviewer. The discussion is relaxed, comfortable, and often enjoyable for participants as they share their ideas and perceptions. Group members influence each other by responding to ideas and comments in the discussions. (Krueger, 1988 p. 18)

Focus groups were first used in the field of sociology in the 1940's and were then discarded by the social sciences. Focus groups were still used in marketing and business but not in scientific research. The disappearance of focus group research can be credited to the reluctance of the social sciences to accept qualitative research as valuable (Brotherson, 1994). The qualitative research that was considered acceptable consisted of individual interviews and participation observation (Edgerton, 1984).
Focus groups have provided a unique way to examine the family's perception of having an adolescent in residential treatment. Focus groups enabled the researcher to gain contextual data and have a clearer picture of the complexities of how families interacted with the multiple systems involved in residential placements and with the state agencies involved in the placement. Focus groups provided a method to examine any changes in the family's perception of an incident (Brotherson, 1994).

Qualitative methodology has been helpful in researching issues that involve family therapy because it allowed for the existence of multiple realities on a single subject (Lincoln & Guba, 1985). The use of focus groups to gather data dovetailed nicely with qualitative research because focus group interviews were designed to elicit multiple perspectives as well (Brotherson & Goldstein, 1992). Focus groups have been well suited to inform and assess existing policy and practice (Brotherson & Goldstein, 1992; Krueger, 1988; Stewart & Shamdasani, 1990). They enabled the researcher to collect the informants' perceptions on the delivering and receiving of services. They have also been helpful in providing information about the implementation of both the letter and intent of the law.
Along with the advantages of focus group research there have been some disadvantages. Krueger (1988) divided the disadvantages of focus group research into six categories. 

- The researcher does not have as much influence about what topics are discussed. 
- Transcripts are more difficult to analyze when multiple informants are being used. 
- Focus groups require the interviewer be skilled and knowledgeable in group work. 
- Each focus group is different and comments vary considerably from group to group. 
- It is difficult to assemble people for focus groups. 
- The focus group must meet in a place which is conducive to conversation.

Focus groups have provided a context in which the researcher can hear perceptions, attitudes and experiences from many points of view (Patton, 1990). Group interaction may be different from individual interviews in that informants build from the comments of others to develop new data and insights which otherwise would not have been available to the researcher (Brotherson, 1994; Morgan, 1988).

As mentioned before, to ensure the integrity of the methodology used in this research the indicators of rigor as described by Lincoln and Guba (1985) were followed. The credibility of the data was insured through the use of
multiple methods, progressive subjectivity, multiple researchers, and member checks. The techniques of group debriefings, multiple researchers, and audit trials provide dependability, while complete contextual descriptions, multiple groups and purposive sampling helped insure the data were trustworthy and transferable.

Focus group research has usually been used as part of qualitative methodology within an emergent design. The recursive nature of the focus group process has not allowed the researcher to use a set or template model for conducting focus groups. The following was not the only way to conduct focus group research, rather, it was a method developed by Brotherson (1994) to incorporate the indicators of rigor (Lincoln & Guba, 1985) discussed earlier.

Examine the problem and formulate research questions.

In this stage the researcher defined the nature of the study. This determined the initial research question(s) and the framework used in the investigation of the question. The qualitative researcher needed to ask: What is the purpose of the study? What knowledge is to be gained by this study? Who will this information be for?

Qualitative research has recognized that the researcher's values impact the informant (Stainback & Stainback, 1984). The researcher must be able to articulate to him/herself and
others the values they hold and their possible impact on the data.

**Identify selection criteria and select participants.**

Purposive sampling provided sufficient diversity by allowing the researcher to identify specific criteria as relevant to the research question and select individuals who represented the targeted diversity (Guba, 1981). Purposive sampling was very important in the organizing of the focus group. The informants who made-up the focus groups were the ones who provided the perceptions used to evaluate the residential treatment program under study.

The objective of purposive sampling has been the selection of participants who can provide useful and rich information for the study. Purposive sampling enabled the researcher to have the right "mix" of informants: The researcher can select informants of varying races, socio-economic levels, and family structure to ensure a richness and diversity in the data provided.

The number of participants in focus groups has usually ranged from six to eight members. Depending upon the skill of the interviewer, the number of participants can vary.

**Develop focus group protocol.**

There were several issues involved in developing the protocol for focus groups. The researcher needed to consider whether the informants will be paid for their services, the
location of the focus group(s), what questions are to be asked, and how the data will be recorded (Krueger, 1988).

Compensating informants for their assistance helped the research by providing incentives for those targeted by the purposive sampling. This incentive may be a service the researcher will provide, money, or information about the study.

Ideally the focus group should be conducted geographically close to the informants. If this is not possible, the researcher should provide transportation or additional compensation. Regardless of its geographic location, the focus group should meet in a comfortable, private, and quiet location.

Usually focus groups have been audio-taped and then transcribed (Bernard, 1988). Other recording methods have included taking field notes and video-taping.

The other critical issue in this planning segment was to design the actual questions for the focus group. The researcher should plan three to four broad research questions and then use specific questions as follow-up responses (Brotherson, 1994). The interviewer should allow time for several informants to respond to each question and for informants to discuss their different perceptions and responses. This dialogue may be stimulated by the interviewer to find out how the informants agree and disagree with each
other. The interviewer should encourage the dialogue to continue until the differences between informants are apparent.

**Conduct focus groups.**

According to Brotherson (1994) the first aspect of conducting the focus group was to train the moderator. In order to collect as much data as possible the moderator must establish a trusting and respectful environment at the beginning of the session. This can be accomplished by doing simple things such as, learning the informants names, maintaining eye contact, and providing refreshments. The moderator must also model respect for the opinions of others and be a willing listener.

It is essential that the moderator have basic interviewing skills. The moderator needed to be able to: 1) listen and think at the same time, 2) reflect the informants' content and attitudes being presented, and 3) ask effective questions (Brotherson, 1994).

Emergent design meant the researcher had to be prepared to alter the general and specific questions to reflect any changes in the research direction; however, the research had to maintain some consistency in the questions to accentuate the uniqueness of each focus group.
Analyze qualitative data.

The goal of analyzing data was to reduce large quantities of information to essentials (Bernard, 1988). Methods of analysis have included case studies, content analysis, and clustering. The specific method used in this study has been discussed in detail in the next chapter.

Just as qualitative researchers have embraced the notion that differences in the perceptions of the informants are valuable, it has been accepted that different researchers may draw different conclusions from the same data. Differences in values, life experiences and training may account for these differences, but, to allow others to track and confirm the conclusions, the researcher should use a systemic and verifiable process.

Report focus group interview data.

While reporting the data the researcher had to keep several points in mind. First, identify the audience and be mindful of the purpose(s) of the study. Second, let the problem question determine the "slant" taken with the data. Third, focus on the most important topics and strive for a complete description of them.

At this phase of the research the researcher can use a final member check to verify the information by presenting it to the informants for feedback. The informant(s) have the opportunity to provide additional comments, clarification,
point out researcher bias, and attest to the accuracy of the data.

**Summary**

The literature review showed that family involvement was a key factor in the child's ability to function after discharge (Carlo, 1985; Stewart, 1984), that the family can provide explanations for the child's placement (Weisfeld & Laser, 1977), and elucidated the mandate the Adoption Assistance and Child Welfare Act of 1980 has for the involvement of families in treatment. Although the professionals were aware of the value and importance of involving the family, there have been no studies designed to understand the family's perception about residential treatment and how they would like to be involved in the treatment process. The literature review demonstrated the need for a study to develop an account of the experience of families who had an adolescent in residential treatment by demonstrating the need for family involvement in treatment and the need of professionals to know how to involve families in treatment.

This chapter contained overviews of qualitative research, the use of focus groups as they relate to family therapy, and the characteristics and objectives of residential treatment. The following chapter will deal with the participants, procedures, and method of data analysis used in the study.
CHAPTER 3
METHODS

This section will describe the informants and the focus group process used in the study. It also includes a description of the procedure used for data analysis. Indicators of rigor, that is, the techniques to insure rigor, have been integrated throughout this section.

Informants

The informants in the study were selected using a purposive sampling procedure (Glaser & Strauss, 1967). Purposive sampling focused on selecting informants who met identified relevant criteria. The criteria for families to be used in the study were identified by the researcher and Stratford Homes' staff as those characteristics which best represented the families served by Stratford Homes. The informants were families that had an adolescent who had received treatment at one of the four residential treatment centers operated by Stratford Homes. This research defined family as: intact, single households, parent with a paramour, and blended families. Informant families were also selected based on the child's gender, the rural or urban location of the family, and the family's economic status. The researcher paid the informants $25 for their assistance in the study.
The research used purposive sampling, rather than random sampling, because the perceptions of the most verbal and articulate parents of adolescents who had received treatment at Stratford Homes were sought rather than a broadly representative sample.

To begin the selection process the researcher contacted the directors of the four Stratford campuses. The directors were given an overview of the goals and methodology guiding the research project and asked if they would be able to help. The researcher explained that this project required that the informants be parents of an adolescent who had received treatment at Stratford Homes. The other characteristic that the researcher wanted in his informants was the ability to articulate their experiences and perceptions of Stratford Homes. In addition, the informants had to be representative of the population of Stratford in regards to socio-economic level, family structure, race, gender, and rural versus urban setting. All of the directors said they would cooperate with the researcher.

The directors said the instructions were quite clear and that they would meet with their staffs and generate a list of potential informants. Within three weeks, three out of the four directors had completed a list and had forwarded it to the researcher. The fourth director was contacted again and asked to supply a list of informants. Although the director
said that a list would be forthcoming, it was never received. The total number of names given to the researcher to contact was 42. The researcher did check to insure that the individuals met the research criteria. No one was eliminated as inappropriate for the study. Nearly 40 percent of the individuals were eliminated as potential informants because there was no current address or phone at which to contact them.

The researcher contacted the remaining potential informants by telephone to determine whether they were interested in participating in a focus group. Each potential informant was given an overview of the research project and told what would be asked of them. They were told that the focus group would last from an hour-and-a-half to two hours, they would be asked about their experiences with Stratford Homes, the session would be audio taped, their input would be kept confidential, and that they would be paid $25. Those interested were asked what time and location would be most convenient for meeting. After contacting the potential informants and determining their interest in participating in the research project, the time and location were selected for the four focus groups. The interested informants were then contacted again to insure that they would be able to attend. Of the 28 parents contacted a second time, 26 of them said
that they would be able to attend one of the four focus groups.

The sample consisted of 17 parents from midwest families who participated in one of four focus groups. The basic demographic information on the parents has been listed below.

- Gender: Thirteen women and four men.
- Age: Informants ranged in age from 29 to 58 with the median age of 41 and a mean age of 41.
- Educational level: Three with partial high school attendance, four with a high school diploma or GED, five with some college or vocational training, and four who were college graduates. One of the participants did not respond to the educational question.
- Family income: Ranged from $5,000 - $10,000 to $51,000 - $74,000 with a median income range of $31,000 - $40,000.
- Race: Fourteen of the informants described themselves as Caucasian and the other three described themselves as Native Americans.
- Rural or urban: Four of the informants came from a rural setting and 13 were from an urban setting.
- Family structure: One family with the biological mother and a step-father, one with biological father living with a partner, one with biological mother living with a partner, one biological father with no partner, two with a biological
mother and no partner, five with a biological father and a step-mother, and six with the biological mother and father.

The number of parent-informants used in the study was 17. The 17 parents participated in one of four focus groups and completed a family questionnaire. Four of the 17 parents participated in a member check which was conducted on the telephone. There were four professional-informants in the study. Three of the professionals participated in a member check conducted over the telephone and the other professional participated in a member check conducted in person. In addition, 11 professionals participated in the peer debriefings conducted throughout the time data was being collected.

**Procedure**

This section will include a detailed account of the development of the study and how the data were collected for the study. Integrated in the account of data collection is a description of how these procedures reflect the concepts of trustworthiness as described by Lincoln and Guba (1985).

A Stratford Homes representative asked the researcher to conduct a research project to record parents' perception of Stratford Homes' treatment process. The study was designed to be a prelude to an outcome based study planned for the future. The researcher enthusiastically agreed to conduct the study.
The intention of the study was consistent with the researcher's conviction that the most useful approach to residential treatment was one which valued, and encouraged, the involvement of parents in the treatment process. The researcher saw the study as an opportunity to improve the delivery of family-guided services by Stratford Homes. The researcher was also aware that the study would provide him with the opportunity to improve his understanding and delivery of family-guided services.

To fund the research project the researcher applied for a Grace Olsen Student Research Award through the College of Family and Consumer Science at Iowa State University. The researcher received $1000 to use in the research project. The Grace Olsen Student Research Award enabled the researcher to pay the informants $25 for their cooperation in the study. The decision to pay the informants was based on the researcher's desire to treat the informants with respect and to compensate them for their time and travel. The researcher also submitted a request to the Iowa State University Human Subjects Committee and received their approval to conduct the study.

The researcher had worked for Stratford Homes as a family therapist for one year. In that time he became familiar with Stratford's philosophy for change and its treatment process. He was involved in all levels of treatment and developed a
comprehensive picture of the duties of the different staff positions and a thorough knowledge of Stratford's philosophy and their treatment goals.

The researcher's prolonged engagement allowed him the opportunity for persistent observations of the treatment process. This enabled the researcher to maintain his focus and avoid side issues. In other words, the researcher's familiarity with Stratford Homes' procedures, personnel, and policies meant he was able to keep the discussion focused on treatment issues and avoid emotionally reactive issues such as how the child was pulled from their home and how unfairly the court system had treated the family.

Before any research focus groups took place, a pilot focus group was conducted to secure feedback about the clarity of the question, the appropriateness of the questions to the research, and to determine which technical areas the interviewer needed to improve. The informants used in the pilot focus group met the criteria that had been developed for the informants in the research project. The pilot focus group lasted nearly two hours and was audio taped. The researcher reviewed the audio tape and feedback from the informants to fine-tune the research project. The pilot focus group helped acquaint the researcher with what it was like to conduct a focus group and provided him with the confidence to lead the subsequent focus groups.
The researcher had limited experience in conducting focus groups prior to the research project. The researcher did have extensive training and experience as a family therapist and had conducted therapy groups prior to facilitating the focus groups for the study. The researcher's therapeutic experience had developed his abilities to listen and assess information simultaneously, ask appropriate questions, and think on his feet.

The focus groups in this proposed study followed a five step outline as described by Greenbaum (1988) which was slightly modified to meet the needs of this research project. Following the outline will be a more detailed account of how the focus groups were conducted.

1. Pre-session planning
   - organize interview setting
   - check recording equipment
   - provide refreshments
   - sign consent forms
   - complete parent questionnaires

2. Introductions
   - welcome and introduce participants
   - provide overview of the process to be followed
   - outline the rules of the group
   - give the objectives of the group
stress the importance of hearing their perspective on issues discussed

3. Easing into the discussion with simple non-threatening questions
   have participants provide background information about themselves
   moderator begins with a general topic discussion

4. The interview/interaction
   ask questions
   track for follow up questions
   get feedback from other group members
   get examples

5. Closing
   answer any questions
   secure cooperation for a telephone follow up interview
   thank the participants for their help

In the pre-session planning, an important consideration was to provide a context that would help the informants feel relaxed and comfortable. To help create that context the researcher arrived at the focus groups one hour before the starting time to set things up and to greet the informants. The researcher engaged the informants in conversation and introduced them to the other informants during this informal point in the process. The pre-session portion also provided
time for the parents to complete the family questionnaire and family identification form.

During the introduction portion of the outline it was vital that the informants have a clear understanding of the research question, what was expected of them, and an overview of the focus group process. The researcher stressed to the informants that there were no right and wrong answers and that their honest opinions were important.

During the easing in section of the outline, the researcher wanted to make sure that the informants remained comfortable about the process. Since the informants had been told what the focus groups were about when they agreed to participate, most of the informants came prepared for discussion.

In the fourth section, the interview, the main concern of the researcher was to explore each point as completely as possible. This often involved additional questions and/or asking the person to provide examples.

In the final portion of the focus group, the researcher made certain that informants had exhausted their points. He also wanted to be sure that the parents felt comfortable with the process and would cooperate in a follow-up telephone conversation if needed.

The researcher used an emergent design in this study, therefore, there was not a set of questions that were asked of
each focus group. The initial set of questions were developed in conjunction with the Stratford Homes treatment staff and the major professor in charge of the study. The questions were designed to collect information on the parents' experience of having an adolescent in treatment at Stratford Homes. The questions that were asked of the informants in some form are listed below.

1. From the family's point of view, what has been helpful or not helpful about Stratford Homes' treatment process?

2. How, if at all, has the family felt it was a part of the treatment process?

3. In which of the following areas would the family have liked to have been involved?
   - Parent discussion groups
   - Parent education/training
   - Involvement in cottage life
   - The setting of goals
   - Phase promotions for the adolescent
   - Knowledge involved in phase promotion
   - Involvement in promotion process

4. From the family's point of view, what role has family therapy had in the treatment process?

5. From the family's point of view, how could the effectiveness of family therapy have been increased?
6. What advice have families for parents who are just beginning to work with Stratford Homes?

7. What advice have families for professionals who work with families at Stratford?

The focus groups were conducted in three different geographic regions in the state. The decision to conduct the focus groups at various locations was made to enhance the diversity of the informants participating in the study.

The researcher enjoyed the experience of conducting focus groups. Conducting the focus groups was similar to therapy in that the facilitator had to keep the informants focused on the question at hand, foster an atmosphere of openness and trust, be prepared to explore interesting and relevant side-issues, and allow everyone the opportunity to speak. The only aspect the researcher found frustrating in the focus group process was that nine parents said they would attend a focus group, but did not. The researcher had double-checked with all of the parents to ensure their attendance and was frustrated, but not surprised, when they did not follow through with their commitments.

A strength of the focus group process was the interaction which occurred between informants. For many of the parents this was the first contact with other parents who had a child placed in Stratford Homes. When the parents had their perceptions validated by other parents it encouraged them to
divulge more information. Unfortunately the converse also occurred. When a parent's experience was not validated by the other parents the parent tended to become less willing to share with the group. The researcher's experience as a therapist was helpful in re-engaging the reluctant parents.

**Trustworthiness of the Data**

Credibility

Peer debriefings about the data were performed after a focus group, or anytime a significant amount of data had been generated. The information collected at the latest focus group was presented at the weekly staff meeting. These staff meetings were attended by the campus director, assistant director, social workers, school coordinator, recreation director, family therapist, and nurse. Findings were discussed in the weekly cottage meetings. These meetings were attended by the cottage social worker and the four residential counselors assigned to that cottage. There were also regular discussions with other family therapists employed by Stratford Homes. With the presentation and discussion of the data in these meetings, all levels of treatment and personnel were involved in the peer debriefing.

The peer debriefings, especially those with family therapists, helped the researcher develop his "hunches" about significant data being presented by parents. The researcher
took his muddled ideas and talked with the therapists until the ideas made sense. Research questions were then developed and/or refined to collect more data in the area of interest. The peer debriefings also helped keep the researcher focused on the research question. When the researcher began to lose focus the other professionals were quick to bring him back on task.

Triangulation, which is the use of multiple informants and/or methods in order to cross-check data and interpretations (Guba, 1981), was implemented by meeting with multiple families in four different focus groups. In addition, data were collected by telephone interviews and through a written questionnaire.

Member checks, presenting findings to the informants for feedback (Guba, 1981), were conducted at various levels. In focus groups 2, 3 and 4 this was done by asking informants for their reactions to, and comments about, information generated in previous focus groups. The informants could agree and/or disagree with the data and could elaborate on points that were still unclear to the researcher.

Four member checks with parents were conducted over the telephone. The most articulate informant from each focus group was contacted by telephone and told of the researcher's findings. All four of the parents contacted by telephone said
that the researcher was on target with his presentation of the parents' experience in working with Stratford Homes.

Four member checks with professionals from Stratford Homes were also done. The researcher presented a summary of the domains to a residential counselor, campus director, family therapist, and staff psychologist. The professionals provided the researcher with their perception of the domains and a justification of their treatment process. The results will be presented in chapter 4.

The researcher conducted a final member check after the data had been analyzed and the results and discussion chapters written. The researcher met with a campus director, an assistant director, three social workers, an education director, and staff psychologist and reported his findings. The staff validated the researcher's findings and theoretical explanations.

Transferability

This research project was designed to generate a thick description of the family's perception of Stratford Homes' treatment process. A thick description involved gathering large amounts of data at multiple levels regarding the issue being studied (Lincoln & Guba, 1985). This increased the transferability of the data; that is, although the data cannot be generalized to all treatment facilities, in similar
contexts this data will be helpful in understanding a family's perception of the treatment process and help in the designing of interventions for them.

Dependability

Dependability involved the consistency of the methods used to gather data. To ensure dependability an audit trail, in the form of field notes, covered the interviews done in the course of the research. Meetings were conducted with the major professor in charge of the research project to support methodological decisions made in regards to the project.

The use of an overlap of methods checked the consistency of data gathered. The research project used focus groups, telephone interviews, and questionnaires to collect information about the families' perspective (Guba, 1981). The questionnaire used a Likert scale to assess how family-guided Stratford Homes were in their therapeutic process. The questionnaire will be discussed in chapter 4 and a copy of the questionnaire has been placed in Appendix C. The methods were different enough that the strength of one covered the weaknesses of the other. For example, focus groups and telephone interviews provided different contexts for the informant to respond. The focus group generated group ideas while the phone interview "protected" the person from being swayed by group opinion. In addition, some informants
preferred the face to face time with the researcher while others liked the safety and distance provided by the telephone.

Confirmability

Triangulation, as already noted in relation to credibility, provided confirmability of the data. Triangulation involved the use of multiple informants, 17 parents and four professionals. The multiple methods for the collection of data included the use of focus groups, individual phone interviews and written questionnaires.

Data Collection and Analysis

The following is an overview of how the data were analyzed in this study. All focus groups were audio taped and the tapes were transcribed. These data were analyzed using the developmental research sequence method (DRS) of Spradley (1979), to generate domains of meaning.

The domain analysis consisted of four separate examining processes: The first order of analysis involved simply reading the transcription of the focus group. In the second order of analysis, synthesized statements, summarizing thoughts expressed as well as key words and phrases, were pulled from the texts. The third order of analysis involved the placing of the key words and phrases into categories based
on their similarities of meaning within families. In the final order of analysis, the categories of meaning were collapsed into domains of meaning based on similarities across all informant families.

A difficult aspect of the data analysis was the identification of significant ideas. Because of the methods used in the collection of data, it was not plausible to identify significant ideas based solely on how frequently an idea was mentioned by an informant. The researcher identified two reasons for the difficulty. First, the methodology used in the study had an emergent design. Therefore, the questions posed in the study were continually being developed and refined throughout the study. Since new questions and new versions of old questions were used over the course of the study each focus group had a slightly different focus. As a result of the different focuses the informants did not have an equal opportunity to comment on the ideas being explored. For example, the impact of divorce on the treatment process was not discussed until the second focus group. The parents in focus groups 2, 3, and 4 were able to comment on this idea while the parents in focus group 1 did not have the same opportunity. The frequency of comments on the impact of divorce was altered by the fact that the parents did not have an equal opportunity to comment on the idea.
Second, the use of focus groups, instead of individual interviews, expanded the methods the informants had for expressing their ideas. Rather than being limited to their own words to express their thoughts, the informants were able to use the words of other informants and body language to express ideas. For example, rather than reiterate the comment of another parent, a parent may simply say "I agree" or some other verbal version of "ditto" to express their agreement. There were times when one parent expressed an idea while other parents shook their heads in agreement. On other occasions the less vocal members of the group allowed the more vocal members to speak for them. In all three cases one comment represented the views of multiple parents.

Due to the methodological considerations stated above, the researcher did not use frequency as the only gauge to weigh the significance of a comment. The other issues considered when determining whether or not a comment was significant were the researcher's field notes and his prolonged engagement at Stratford Homes. At the conclusion of each focus group the researcher recorded what had impressed him as significant ideas. These thoughts were the basis for new questions and the refinement of existing questions. The ideas from the field notes also provided a lens for the analyzation and interpretation of the data.
The researcher's prolonged engagement at Stratford Homes helped the researcher identify significant comments made by parents in the focus groups. The researcher had had contact with over 60 parents during his tenure as family therapist at Stratford Homes. The researcher had also attended over 50 staff meetings and over 70 quarterly staffings. The experience of talking with the families about treatment and staff and talking with the staff about policies and families had placed the researcher in an unique position. The researcher was aware of how the different systems operated and what the different systems were saying about each other. This allowed the researcher to hear comments from multiple positions. For example, when a parent made a comment about the difficulty of working on family problems with his ex-wife, the researcher was aware that this was something that the staff had not discussed. Rather than let the parent's comment pass, the researcher asked additional questions and collected important information on the issue.

The referencing and clustering of the important phrases from each focus group aided the content analysis. Creating clusters made the data set more manageable, although some relevant material could be lost in the analyzing process. To guard against the loss of important information and to check the "accuracy" of the categories being created, the researcher did an inter-rater reliability check: Two people abstracted
the material from a portion of the data. The generated key words and phrases were put into categories. A comparison of categories allowed the researcher to see if there was similar information present and if it had been placed into similar categories. If there were consistent differences in the categories being generated, the individuals went back to the original transcripts to examine the information in the context.

Limitations

There were two important issues regarding the transferability of data from this study. The research focused on the families' perception of Stratford's treatment process. Thus, the perceptions of these families may not be the same as the perceptions of families involved in some other type of treatment facility. In addition, 82% of the informants in the study were Caucasian and 18% were Native Americans. Purposeful sampling still did not gain a more racially diverse sample.
CHAPTER 4
RESULTS

The design of the present study developed an initial ethnographic account of the family's perspective of residential treatment at Stratford Homes. The study, done as a mini-ethnography, did not involve the analysis and documentation of quantitative data, other than for demographic purposes and for a member check. Transcripts of moderately structured focus groups, which involved parents whose children had been treated at Stratford Homes, provided qualitative data. The transcribed interviews were analyzed using a domain analysis as described by the Developmental Research Sequence (DRS) of Spradley (1979).

Two types of domains will be examined in this section: Imposed domains and emergent domains. Imposed domains are domains which involved a direct reaction to selected, or a priori, specific questions. Emergent domains are those resulting from the post hoc evaluation of the transcripts from the four focus groups. Focus groups for the study were designed to cover the specific topics of quarterly staffings, home visits, phase promotions, advice to parents, advice to professionals, family therapy, contact with other parents, and involvement in treatment. These domains became the imposed domains. During the four focus groups, six more domains
emerged during the course of the conversation. These domains included triangulation, sharing information, families with divorce, making decisions, getting to know the family, and the pre-visit.

The results of the qualitative data, developed from the domain analysis, will be presented in this section. The results included an overview of the imposed and emergent domains, a description of characteristic comments, and a short elaboration of each domain. A more complete description of the domain analysis will be presented in the following section. This format will provide the reader with an overview of each domain and acquaints him/her with the key words, phrases, and terms that were used by parents to describe the experience of having an adolescent in residential treatment.

The use of an emergent design allowed the researcher the flexibility to pursue interesting data and explore relevant avenues not anticipated in the original research proposal. The analysis and reporting of the parents' experience satisfied the intention of the original proposal but did not satisfy the curiosity of the researcher.

Rather than be content with a lineal study, the researcher took the data collected and reported it to the professionals interviewed for the study to provide them with the opportunity to respond to the parents' comments. This process added a recursive element to the study which reflected
the systemic epistemology in the field of family therapy (Bowen, 1990; Keeney, 1983; Watzlawick et al., 1967). The researcher could have taken the professionals' response back to the parents for their response to the professionals' response to the parents' perception of residential treatment. The process of sharing the responses of one system with the other could be carried out indefinitely, but the researcher decided to stop the sharing at this point in order to keep the study manageable, not because he thought "all" of the sharing has been completed.

The act of sharing the views of one system with another system, with the intention of improving their working relationship, is isomorphic to the therapeutic process as described by Boszormenyi-Nagy and Spark (1973). The researcher, like the therapist, had individuals state their perception and then had professionals respond to their perception. In the therapeutic relationship this sharing was facilitated until all sides felt heard and had reached consensus.

This section will report the results of the focus groups, the professionals' response to the parents, and the findings from the family questionnaires. The family questionnaires, along with the telephone calls to focus group informants and professionals, served as member checks in this study. The
information from the telephone calls to parents was integrated into the focus group data.

Analysis of Qualitative Data

Fourteen domains of meaning emerged from the interviews with 17 parents who participated in the focus groups. The domains represent how these parents experienced their child's residential treatment at Stratford Homes. Eight imposed domains were defined prior to the interviews and were used to structure the overall discussion. Six additional domains emerged from the parents' discussion.

This chapter will contain descriptions of the 14 domains developed by the study. Each domain has been divided into three sections. The "domain" section includes the title and a brief description of the domain. The "characteristic comments" section contains a sample of the comments made by parents regarding the domain. Not every comment made by parents regarding the domain was listed. Instead, the researcher listed the comments which best represented what parents had to say about the domain. By selecting the most salient comments the researcher has provided the reader with a precise and concise view of the data. The characteristic comments are presented from most common comments to least common comments. The "elaboration" section contains a narrative description of the characteristic comments. The
"elaboration" section has also been organized from most common comments to least common comments. In the "elaboration" section, all means that the 17 parents were in agreement on the subject, nearly all has 14-16 comments, majority has 10 to 14 comments, most has 6 to 9 comments, many has 3 to 5 comments, a couple has 2 comments, and one has one comment.

Imposed domains

Domains that were imposed by the moderately structured interview included: Staffings, home visits, parent support groups, family therapy, phase promotions, involvement in treatment, and advice to parents and professionals involved in residential care.

Domain: Quarterly staffings. This domain included those characteristic descriptions of what the family members found helpful and not helpful about the quarterly staffings.

Characteristic comments: Quarterly staffings.

• Notification and time

  Didn't get a letter telling about the staffing.
  Not notified about staffing.
  Other parents (divorced) told but not me.
  Held during parent's working hours so they were unable to attend.
Not involved in the setting of time.
Prefer being notified by the telephone.

- **Attendance**
  Involve everyone who works with the child, how else are you going to get the whole picture?
  Involve everyone who works with the resident.
  Like to see the people that deal with my daughter attend the staffings.

- **Focus**
  Don't make the parents the focus.
  No need to focus on the parents.
  Like to hear the strengths and weaknesses.
  Want an honest evaluation of the child.

- **Organization**
  Talk to the parents before the staffing and let them know what is going to happen.
  Need an agenda and to be more organized.
  Keep to one hour.
  Staffings are designed for the referring workers.

- **Overview**
  Like to have a staffing every month.
  Fairly informative.
  Fairly good exchange of information.
  Place to get the day to day information.
  Only chance to hear what they think of your child.
Elaboration: Nearly half of the parents reported missing a staffing because they had not been notified of the staffing or the staffing was set at a time when they could not attend. The parents were particularly sensitive to the lack of notification when there were two sets of parents involved with a child and one set of parents was notified and the other set was not. Many parents reported that they preferred notification by telephone rather than by letter.

An important issue to the nine parents of focus groups 1 and 2 was the attendance of the professionals who worked with the child. Parents said that the staffings usually consisted of the resident, the referring worker, the parent(s), the cottage social worker, and the residential counselors. The parents said that it would have been helpful to have had the other professionals (family therapist, nurse, recreation therapist, and education coordinator) attend the staffings so that they could get the "whole picture" about their child.

The 3 parents in the first focus group felt strongly that the focus of the staffings should be on the child and not on the family. A personal comment to a parent by a Stratford Homes staff member or referring worker was perceived as inappropriate. Many parents from the other focus groups reported that it would have been helpful to have heard
negative and positive comments from Stratford staff about the child and his/her progress.

Many of the parents had suggestions for improving the organization of the quarterly staffings. One parent thought it would have been helpful for the professionals and family to meet without the child present. This would provide the parents and staff a time to coordinate their efforts without the child's knowledge. It would also allow the parents and staff to share information that was not appropriate/helpful for the child to hear. Many other parents in the focus group agreed with the parent's comment. A couple of parents reported that the staffings were geared towards the referring worker rather than towards the family. A parent also reported that the staffings should not last longer than an hour.

Overall parents reported that the quarterly staffings were very important to them. Staffings were seen as informative and helpful to the family. In fact, one parent commented that she would have liked to have had the staffings on a monthly rather than on a quarterly basis. A couple of other parents agreed with her comment. For many of the parents the quarterly staffings were the only time they had to talk with the Stratford staff about their child. The staffings were the parents' opportunity to get information regarding the day to day activities of the child and to ask questions regarding their child's progress.
Domain: Home visits. This domain included those characteristic descriptions of what the family members found helpful and not helpful about the child's visits to the home.

Characteristic comments: Home visits.

• More home visits
  Allow the child to earn more home visits.
  Want additional home visits.
  Want more home visits so that child can stay involved with the family.
  If goal is family reunification then there should be more home visits.
  Would like more home visits after the 30 day waiting period.

• Home visit forms
  Design the home visit form to fit the child's need.
  Use family therapy as a time to develop home visit form.
  Would like feedback from staff about the home visit forms.
  Wrote nonsense on the home visit form and still did not hear from the staff.
  Would like a telephone call from staff about how the home visit instead of filling out a form.
  Not comfortable with some of the questions on the home visit form.
Not all questions can be answered with a simple yes or no.

- Decision about home visit
  Would like to be informed about the child's behavior and then decide if he/she deserves a home visit.
  Decide in family therapy if the child will get a home visit.
  The parents, not Stratford should decide if there will be a home visit.
  Parents should be allowed to turn a day visit into a home visit.

- Cancellation of home visits
  If family reunification is the goal the home visit should not get canceled.
  Should not cancel home visit because of a peer's behavior.
  Home visit should not be canceled because the cottage staff made a mistake.
  Would like to be consulted before a home visit is canceled.

Elaboration: All of the parents would have liked more home visits. Home visits were seen as the best method for maintaining a sense of closeness between the child and the family. Many of the parents said that an increase in home
visits would help them achieve the goal of family reunification quicker by helping the child and family stay involved with each other. A couple of parents said that residents should even be allowed to earn additional home visits.

Nearly all of the parents had some feedback about the home visit forms that were to be completed for each home visit. The most common complaint was that the cottage staff did not provide the parents with any feedback about the forms. Many of the parents reported that the staff did not give them any indication that their comments had even been read. One parent said that once she wrote nonsense on the form just to see if they would respond, they did not. A couple of parents said that it would have been helpful to have at least received a telephone call or letter acknowledging that the comments had been read.

Many of the parents would have liked the questions on the form to be individualized to the child. One parent suggested that the family could decide in family therapy, or with the cottage staff what areas should be covered by the home visit form.

A couple of the parents commented that the some of the questions on the home visit forms required more than the yes/no response which was allowed. Parents would have
preferred the option of responding with an "I don't know" or a "yes/no" and fill in the blank.

A couple of parents, in different focus groups, reported that it would have been helpful to replace the home visit form with a telephone call from the residential counselor. This would have allowed them to be more precise in their responses and to have gotten immediate feedback from the cottage staff.

All six parents in the second focus group would have liked to have been more involved in the decision about whether the child would get a home visit. It would have been helpful to have known how the child was behaving in the cottage so they could decide if they wanted him/her home and/or if he/she really deserved to go home.

Most of the parents were not satisfied with the procedure that was used to cancel a home visit. All three of the parents in the fourth focus group said it was unfair to cancel a home visit for something done by someone else in the cottage or because of an oversight by the cottage staff. The parents in the fourth focus group wanted to be involved any time a visit was canceled. The parents were not questioning whether a cancellation was ever valid, rather they wanted the opportunity to have their wishes known. One parent had been informed that a home visit had been canceled when she arrived at the cottage to pick up her child.
Domain: Phase promotions. This domain included those characteristic descriptions about understanding and participating in phase promotions.

**Characteristics comments: Phase promotions.**

- **Information about the phase system**
  
  Give parents a copy of the phase packets.
  
  Not clear about the phase system.
  
  Would like more information about the phase systems.

- **Involve parents in phase system**
  
  Make phase promotion a part of each home visit.
  
  Involve parents in phase promotions.
  
  Would help "push" resident if they knew the goals of each phase.

**Elaboration:** Parents from all four focus groups commented on the need for more information about the phase system. Parents reported being confused by the concepts of levels and phases and would have liked a description of each phase and its purpose. Most parents agreed that they felt like they "were in the dark" when it came to the phase packets.

One parent commented, "if I knew what she was suppose to do in phase 1 I could hold her feet to the fire." The other parents in the focus group agreed with her comment. Another
parent suggested making the phase material part of the home visit form which would make it easier for the parents to be involved in this aspect of the child's treatment.

One parent got the approval of her peers when she suggested that parents be involved in promoting the child from one phase to another. This would tie the parents directly into treatment and help the parents be more aware of their child's progress in treatment.

Domain: Advice to parents. This domain includes those characteristic descriptions of advice to families who are just beginning to work with Stratford.

Characteristic comments: Advice to parents.

• Working with professionals
  Learn how to play the game.
  Quit complaining and play the game.
  You have to be pushy at times.
  Learn to speak the professionals' language.
  Get to know the workers.
  Be honest.
  Do what is best for your child.

• Be involved
  Get involved.
  Know what is going on.
Know what is expected of your child.

Support your child.

- Value of treatment

Treatment will be tough, but it will help your child.

It's a good program and it's going to be tough on you.

**Elaboration:** The most common advice offered to parents was how to deal with the treatment professionals. All three of the parents in the fourth focus group emphasized the need for parents to learn how to be "pushy" and how to "play the game." According to the parents in the fourth focus group being "pushy" and "playing the game" involved having the professionals think they were getting what they wanted by not challenging them directly while at the same time keeping pressure on the professionals to get the child through treatment as quickly as possible. If there was something you wanted done and the professionals were not doing it then the parents needed to be "pushy." The most important thing was to do what was best for your child.

The majority of parents saw value in developing a relationship with the professionals who worked with the children. This involved learning the terms and labels the professionals used in speaking to families.

Most of the parents talked about the need to get involved in the child's treatment. Areas to be involved included
knowing what was expected of you, what was expected of your child, and what occurred on a day-to-day basis.

A couple of parents said it was extremely difficult having a child in residential treatment, but despite the difficulties and strains treatment placed on the family, it was worth it.

Domain: Advice to professionals. This domain included those characteristic descriptions of parents' advice to professionals who work with adolescents in residential treatment.

Characteristic comments: Advice to professionals.
• Professionals' work with parents
  Should ask the parents for input regarding the child.
  Remember, the parents know the child better than you do.
  Be aware of how hard it is to leave a child at Stratford.
  Listen to the parents.
  Be honest and open with the parents.
  Talk with the parents until you are sure they understand what you are talking about.
  Put yourself in the parents' position.
  Access the parents' knowledge.
  Remember parents want to be involved in the treatment.
Having a child in a group home is a tough transition for the parents.

- Professionals' work with children
  - Spend more one-on-one time with the residents.
  - Accept the child as an individual.
  - Don't have to change every part of the child.
  - Don't get too close to the resident because the child will use them.
  - Keep a line between personal and professional relationships.

- Use of labels
  - Labels generalize and focus on the past.
  - Don't generalize, treat each child like an individual.
  - Labels put ideas in a child's head.
  - Labels force the child into a box.
  - Don't let a child's past abuse be used as an excuse for inappropriate behavior.

**Elaboration:** A re-occurring theme in focus groups 2, 3, and 4 for was for the professionals to be aware of how difficult it was for a parent to leave a child in someone else's care. The concerns ranged from issues about the child's physical safety to how the family was disrupted.

Many of the parents had suggestions for how the professionals communicated with parents. The underlying theme
in the comments was a call for the professionals to treat the parents with respect. The parents did not like having the professionals talk down to them or not listen to their input on the child's behavior. One parent clearly articulated why professionals should listen to parents, "remember that the parents know the child better than you."

Many of the parents suggested that the professionals spend more time building a personal relationship with the child. A couple of the parents suggested this be done with individual counseling. Another thought the professionals just needed to more available to the residents.

The three parents in the fourth focus group warned the professionals to not get close to the children. The parents were concerned that a personal relationship with the child may interfere with the therapeutic relationship.

At least one parent in each of the focus groups expressed dislike over the use of labels. The concerns over the use of labels ranged from the notion that the child will use the label as an excuse, or "crutch", to the concern that labels create issues. In other words, the child may believe that he/she is an alcoholic if the treatment staff says it enough times.

Another concern with the use of labels was that it stopped the professionals from viewing each child as unique. Many of the parents thought the professionals were not viewing
the child as an individual because they were unable to get past the label.

Domain: Family therapy. This domain included characteristic descriptions of family therapy and its use in treatment.

Characteristic comments: Family therapy.

• Structure of family therapy
  Involve everyone, don't let the child pick who attends and what is talked about.
  Make sure the child deals with both sets of parents.
  The therapist should keep pressure on the child to meet with the parents.
  Therapist should not allow the child to manipulate the family.
  Sometimes the therapist needs to "dictate" what is talked about and who attends.
  Would like the chance to talk to the therapist without the child's presence.
  Would like more individual counseling for the child.
  Therapist should meet with the child individually between family sessions.
• The family and Stratford

Family therapist served as a liaison between the family and Stratford.
Worked out issues with the cottage staff.
Family therapist impacted the way the cottage staff viewed the parent.
Provided a link between the cottage and home.
Helped the family learn how the cottage worked.
Family therapist helped explain the motives of the cottage staff.
The therapist was someone to "vent" to about the cottage staff.

• The family therapist

Kept the atmosphere friendly.
Appreciated the therapist's sense of humor.
Felt comfortable sharing family failures with the therapist.
The effectiveness of family therapy depended upon the family therapist.
It's not family therapy, it's the therapist that makes it work.
Did not have to worry about pay backs from the therapist.
Therapist considerate in setting meeting time.
Therapist contacted the family to start the process.
• Family issues
  If child is in Stratford because of family problems make
  sure therapy deals with family problems.
  Focused on the wrong angle.
  Therapy needs to stay focused on the family issues.
• Aftercare
  Have therapist meet with the family six months after the
  child is discharged.
  Therapist serves as an arbitrator after the child is back
  home.
  Family therapist should meet with the family to see how
  things are going.

  **Elaboration:** An issue that was raised by the five
  parents in focus group 3, and supported by the three parents
  in focus group 4, was the need for the therapist to be more
  assertive about who attended therapy and what was discussed.
  If a child was placed in Stratford Homes because of family
  problems, then therapy should focus on family problems.

  The parents in focus groups 3 and 4 thought that the
  family, rather than the child, should be in charge of the
  agenda for family therapy. When the child was in charge it
  was too easy for him/her to use therapy to make one set of
  parents look bad. The child was also able to manipulate
  therapy so that issues with parents were not addressed.
The parents in focus group 3 thought family therapy could have provided a place for one family to meet with the "other" family. It would have been helpful to have had a forum where they could discuss differences between families without the child present. It was also suggested that when one parent, or set of parents, was unwilling to attend therapy, the family therapist should tell them that "we need to be concerned about what is best for the child" instead of catering to their personal needs.

The parents in focus groups 3 and 4 would have liked the opportunity to meet with the therapist without the child bring present. This would have provided the adults with an opportunity to address issues that were inappropriate to discuss in the child's presence. The three parents in focus group 4 would have liked the therapist to meet with the child individually between family sessions.

Parents in focus groups 1, 3, and 4 reported that the family therapist was helpful in explaining how the cottages and the Stratford Homes' system worked. The family therapist was described as a "link" between the family and Stratford Homes. Family therapy was viewed as a place where the family could "vent their frustrations about the cottage without worrying about pay backs."

Many of the parents said that family therapy was not a cure-all, rather its effectiveness depended on the skill of
the family therapist. Many parents in focus group 1 and 2 commented on the accepting atmosphere of family therapy, were pleased that the family therapist took the time to get to know them as a family, and that the therapist was considerate of their needs when setting a time for the next session.

The family therapist also worked with the family and the child in placement. Families reported that it was a helpful place to prepare for home visits. It was also a forum where they could discuss what was expected of the child when the adolescent was discharged from Stratford Homes and returned home to live with them.

The parents in focus group 3 and 4 would have liked to have used family therapy as a form of aftercare. They would have liked to have met with a family therapist six months after the child had been discharged to deal with new issues and for the therapist to serve as an arbitrator between the child and family, if needed.

**Domain: Contact with other parents.** This domain included those characteristic descriptions regarding contact with other parents and ways to increase its effectiveness.
Characteristic comments: Contact with other parents.

- Support group

  Would like a parent support group not a multifamily therapy group.
  Would like parent support group or a family activity day.
  A group to support each other without criticism.
  A group where parents feel heard.
  Do not want a group where they are told that they are a bad parent.
  Helpful to see that I am not the only parent in this situation.

- Structure of group

  Contact with other parents without children present.
  Have a group which focuses on parenting skills.
  Have a family night.
  Have a potluck dinner for the parents.
  Have parents meet by cottage not as a campus-wide group.
  First 30 minutes with just parents and the last 30 minutes with parents and children.

- May create difficulties

  If parents talk they will learn of the differences between cottages.
  Family night would be difficult for children who have parents that do not attend.
Elaboration: Parents in all four focus groups would have liked more contact with other parents. All agreed that they would prefer a support group rather than a multifamily therapy group. Parents would have liked some type of forum where they could be supported by other parents, hear new ideas on handling difficult situations, and talk with other parents in similar situations.

There was a great deal of diversity among the parents on how a group should be structured. A couple wanted a group for parents only. One parent wanted to divide the meeting into 2 sections with the first section for parents and the second section for parents and children. One parent wanted to meet by cottage, another wanted a campus wide "family night", and still another wanted a potluck dinner.

One parent thought if parents got together it would create difficulties for Stratford Homes as parents became aware of the inconsistencies between the cottages. Another parent said if all the parents did not participate some children would feel left out.

Domain: Involvement in treatment. This domain included those characteristic descriptions regarding the parents' involvement in the treatment process.
Characteristic comments: Involvement in treatment.

- **Goals**
  
  Would like to be involved in the setting of goals.
  Would like to help push the child to achieve their goals.
  Had to push to have any say in the goals that were set for the child.
  Had no input on her goals.

- **Obstacles for involvement**
  
  Told by cottage staff that they were uncomfortable working with parents that wanted to be involved.
  Feel uncomfortable reporting failures to the cottage staff.
  Cottage staff -- doing your job because you failed.
  Felt as they were viewed as the problem parents and the other parents were the solutions.
  Told by cottage staff, "we've got him instead of you and you are on the sidelines."
  Told by cottage staff, "he is no longer yours, he belongs to the state."

- **Involvement of the child's peers**
  
  Would like less of peers telling peers what to do.
  Don't like the idea of peer counseling.

- **Cottage activities**
  
  Involve parents in cottage groups.
Elaboration: A topic in all four focus groups was the parents’ desire to be more involved in the setting of goals for the child. The majority of parents reported that no one from the professional staff had asked them what goals would be appropriate for their child. Tied to the desire to be involved in the setting of goals was the desire to be involved in helping the child achieve the goals.

According to the 14 parents in focus groups 2, 3, and 4 the biggest obstacle to becoming more involved was the cottage staff. One parent reported being told by a residential counselor that the cottage staff was not accustomed to working with parents that wanted to be involved. Another parent saw the cottage staff as having the attitude that "we've got him instead of you and you are on the sidelines." The majority of parents were not approaching residential treatment as a way to avoid problems, rather they were hoping that the treatment would create solutions.

The six parents in focus groups 1 and 4 expressed disapproval about the level of involvement of the child's peers. The parents were uncomfortable with the idea of peers telling their child what to do. The parents did not like the idea of peer counseling. The concern was based on the belief that the peers had just as many problems as their child and should spend their time working on their own issues.
One parent found being involved in cottage activities helpful. It was an excellent way to get to know the social workers and residential counselors. The opportunity to talk with her son in front of his cottage peers allowed her to say things to him that she usually did not say. It was helpful to get feedback from his peers on how they experienced her. In addition, it was helpful for the mother to realize that he treated everyone as rudely as he treated her.

Emergent domains

The six domains that emerged from the informants' conversations included: Triangulation by adolescent, sharing information, families with divorce, making decisions, getting to know the family, and the pre-visit.

Domain: Triangulation by adolescent. This domain included those characteristic descriptions regarding triangulation by adolescents and how it impacted the treatment process.

Characteristic comments: Triangulation by adolescent.
• Staff against family
  My child had them conned but they would not listen to me.
  Child said bad things about me and the residential counselor believed them.
When the staff and family does not get along, the child plays one against the other. Child uses conflict between staff and parent to get his way. The child used his journal to make the parent look bad and the residential counselor never gave the parent a chance to defend herself.

- **Solutions to the problem**
  Communication needs to be a complete circle with everyone talking with each other. The residential counselor's behavior made sense when the parent understood the goal behind the behavior.

- **Staff against staff**
  Even the staff psychologist told the cottage staff that the child was playing them against each other but they still would not listen.

**Elaboration:** Parents in all four focus groups reported incidents where their child had tried to pit them against the cottage staff. The majority of the times the adolescent was successful. Many of the parents informed the cottage staff what had occurred but did not feel as if the staff believed them. A couple of the parents reported that the staff did listen to their concerns.
A couple of the parents had solutions to the problem. One parent used the analogy of a circle. She thought that if the circle (communication) was complete, everyone would be able to work together and treatment would be more effective. Another parent thought individual counseling would be helpful. Individual counseling would provide the staff with a clear picture of how the adolescent manipulated situations.

One parent reported that her son would pit the staff against each other. She said that even after the staff psychologist told them what was occurring they did not change their behavior.

Domain: **Sharing information.** This domain included characteristic descriptions regarding the sharing of information between Stratford staff and the family.

**Characteristic comments: Sharing information.**

- **Day-to-day activities**
  
  Parents would like to know how Stratford handles problems so they can try the same techniques at home.
  
  Would like to know how the child is doing on a daily basis to help with the transition to home.
  
  If something is working at Stratford Homes, let the parent know so they can try it home.
• Information from the parent to the staff
  Not asked to share any information about why the child was being placed at Stratford Homes.
  The parent (divorced) who makes the most noise gets heard.
  The "parent (divorced) who gets Stratford's ear first, that's the key."
  If asked a question received an answer, but Stratford Homes never volunteered any information.
  To get any information a parent must be "pushy."

• The exchange of information
  Moved closer to Stratford Homes and it improved our communication.
  Prefer conversations as opposed to letters.

• How informed
  Felt well informed.
  Knew what was going on.
  Felt "like I was in the dark."

• Major activities
  Was not told of the child's school problems.
  Want more information on important issues.
  Want to be informed of any health and/or academic problems.
Elaboration: Parents in focus groups 2, 3, and 4, especially 3, reported a desire to have more information on the day-to-day activities of the child. Day-to-day activities referred to the child's behavior in the cottage and at school. The parents wanted this information so they could try the same disciplinary techniques when the child returned home, to make good decisions about home visits, and to keep updated about the child's progress in treatment. A couple of parents commented that it was not necessary to have every detail of what occurred, but they would like more information than they had received.

The five parents in focus group 3, and a parent in focus group 1, reported that if a parent wanted the cottage staff to know something they had to volunteer the information because the staff was not going to ask the parents any questions about the child's behavior. The parents said that they always had to call Stratford Homes because no one from the staff had ever called them. The information flow with the cottage staff was similar to involvement in treatment and advice to parents in that it was necessary for parents to get "pushy" if they wanted something done.

One parent said that it would have been helpful if the staff had spent more time collecting and sharing information at the beginning of the treatment process. "The staff would be better off if they got input from all of the agencies and
individuals who had worked with the child in the past." The parent thought this would increase the accuracy of staff's view of the child and the family and shorten the length of treatment.

A couple of divorced parents said the exchange of information between the cottage staff and the two sets of parents was definitely biased. The parents felt that the cottage staff paid attention to the parents that complained the most and/or that who ever got the staff first had the advantage.

One parent said that when she moved closer (one mile away) her communication with the cottage staff improved. A couple of parents commented that they preferred phone calls to letters.

Most of the parents in the study felt as if the cottage staff kept them well informed on the progress of their child. A couple of the parents reported feeling "in the dark."

Many of the parents reported isolated incidents where they were not informed of a major issues like an academic or health problem. When the miscommunication by staff occurred the parents expressed their desire to be kept better informed and the staff responded positively to the comments.
Domain: Families with divorce. This domain included those characteristic descriptions of working with families with divorce and how divorce impacted the treatment process.

Characteristic comments: Families with divorce.

- Taking sides
  Once she (mom) proved she was not reliable we were allowed to be involved.
  Get to know both sides before deciding who is right and who is wrong.
  Did not get as much information as the other parent.
  The staff acted as if one set of parents were the problem and the other set were the solution.
  Don't believe the bad things one set of parents says about the other set of parents.
  Felt like the staff made a choice on which set of parents they wanted to work with.
  The staff believed the negative things the other parents and child said about them.
  Don't inform only one set of parents about staffings.

- Separate and equal
  Not willing to be involved if his mother is going to be present.
  Would like separate family therapy sessions.
  Would like separate quarterly staffings.
Invite everyone to the pre-visit.
Involve both sets of parents in family therapy.

- Involve everyone in treatment
  Difficult to involve everyone that needs to be present.
  The cottage staff let the child decide which parents to involve in treatment.
  Involve everyone.

- Forum for divorced parents
  Would like a forum to discuss issues regarding the other parents.
  Need a place where one set of parents can talk about the other set.

**Elaboration:** The discussion of how the Stratford Homes staff worked with divorced parents was one of the most emotional topics discussed in the focus groups. Parents who were divorced had very strong feelings about how they were treated by Stratford Homes and how Stratford Homes should conduct its treatment process. As the reader can see from the domain categories, there were a wide range of comments on this issue. For example, in focus group 3 one parent did not like it when the other parent gave the staff incorrect information about them. Later in that focus group, a parent commented that it would be helpful to have a forum where parents could
discuss the other parents with staff. The parent who made the first remark did not comment on the second remark.

The five parents in focus group 3, all of whom were divorced, said that the staff at Stratford Homes should not take sides when working with divorced families. The parents in focus group 3 reported that Stratford made a choice about which parent to work with and then the case was closed. One parent said that Stratford was unwilling to work with him until the child's mom "proved" her unreliability and then he was involved. Another parent reported that "from the beginning, they (the staff) thought we were a problem and maybe the other set of parents were the solution." One parent suggested that the staff should not be so hasty in deciding which parent to believe and which to not believe.

All of the divorced parents agreed that all family members should be involved in treatment, but there was considerable disagreement on how to accomplish that task. Many of the parents wanted separate staffings, home visits, and family therapy, while many parents wanted everyone to participate in the same staffings and family therapy sessions. All agreed that both sets of parents should receive the same information, be consulted equally on issues involving the child, and be invited to the pre-visit and staffings.

One parent suggested a forum where parents could discuss issues and do whatever is needed to help the child. Another
parent responded, "We are talking about a child that I love dearly..., but keep me away from my ex-wife -- I don't want to meet with her and deal with her."

**Domain: Making decisions.** This domain included those characteristic descriptions of the process of making decisions and the family's involvement and/or lack of involvement in this process.

**Characteristic comments: Making decisions.**

- Residential counselor in charge
  
  Felt like the residential counselor was in charge.
  
  Was told that you are turning your child over to them.
  
  You have no say so anymore.
  
  We've got him instead of you and you are on the sidelines.
  
  He is no longer yours, he belongs to the state.
  
  We are doing your job because you failed.

- The child in charge
  
  Felt like the resident was in control not me.
  
  Child decided who to meet with and Stratford let him.
  
  Family conflict was the ticket into Stratford, but child did not want to deal with it and nobody made him and it is still a problem.
Elaboration: All of the comments in this domain were made by parents in focus groups 2, 3, and 4. Most of the parents felt as if the Stratford staff made it very clear who was in charge of the child. The following quotes were attributed to cottage staff by parents. "We've got him now instead of you and you are on the sidelines." "You better get the picture, the kid is no longer yours, he belongs to the state." One parent said that the residential counselor came across as, "they are doing our job for us because we failed." The implication was that the parents were being punished and they resented that idea.

One parent reported that when it came to making decisions she felt "powerless." She reported that when she tried to talk to the staff they acted defensively and "labeled her as a troublemaker. They didn't understand that I only wanted to be involved."

Many of the parents reported that the child should not have made the decision on what to focus on in treatment. A parent said that the child's "ticket" into treatment was family problems and he/she should be forced to work on that issue. Another parent made the comment that the child had more say in what was addressed in treatment than she did.

Basically, every suggestion and comment made by the parents in the four focus groups could be referenced back to their desire to be more involved in the treatment process.
Even their attendance was a comment on their desire to be more involved in the process that Stratford Homes used in treatment.

Domain: Getting to know the family. This domain included those characteristic descriptions regarding how parents wanted the staff to take the time to get to know the families with whom they work.

Characteristic Comments: Getting to know the family.

- Cottage staff
  Feel more comfortable with friendly residential counselors.
  When the residential counselors are not friendly, parents feel like outsiders in the cottage.
  Would like for the residential counselors to be there for the parents to talk with.
  Want support from the residential counselors, not advice.

- Visit the family at home
  Have the social worker visit the home.
  Would like a staff member from Stratford Homes to visit the family in their home to get a feel for who they are.
**Elaboration:** A couple of the parents commented on how important it was for them to be on friendly terms with the residential counselors. For those parents the residential counselors set the tone for their experience with Stratford Homes. When the parents were on friendly terms with the residential counselors they were on good terms with Stratford Homes. When the parents were not on friendly terms with the residential counselors they were on poor terms with Stratford Homes.

A couple of the parents mentioned that it would have been helpful for the residential counselors to be available to them as well as to the children. The role the parents would like the residential counselors to fill was not made clear. It was clear that the parents did not want the residential counselors to comment on their personal lives.

The three parents in focus group 4 said it would have been helpful if someone from the Stratford Homes' staff had visited their home. A home visit would have given the staff a better picture of the family. One parent said she was offended when a cottage social worker said it would be inappropriate for her to come into the house for some ice tea.

**Domain: Pre-visit.** This domain included those characteristic descriptions of what was helpful/not helpful about the pre-visit.
Characteristic comments: Pre-visit.

- Exchange of information
  
  Was overwhelmed by all the papers which needed to be signed.

  More information about the rules and the purposes of the rules.

  Chance to learn staff's terms.

  Appreciate the opportunity to meet staff and see the facilities.

  Helped parents feel as if their child was safe.

- Warn of the drawbacks

  Tell parents to expect negative letters from the child.

  Inform the parents of the difficulties.

  Tell parents how long the child may be in treatment.

- Divorced parents

  Both sets were not asked.

  One set of parents gave the staff negative information about the other set of parents.

Elaborations: Most of the parents thought that the pre-visit was a good opportunity to get acquainted with Stratford Homes. Many of the parents reported that it was helpful to see the facilities and to meet the professionals who would work with their child. One parent said that her
major concerns were for the safety of her child. The pre-visit provided her with the opportunity to express those concerns to the Stratford Homes staff. A couple of parents reported that the pre-visit gave them an opportunity to become familiar with the terms that the staff used in working with adolescents.

Many of the parents would have liked more information about the rules and the reason for the rules at the pre-visit. One parent reported being "overwhelmed" with information at the pre-visit and suggested that Stratford reduce the amount of information parents receive when they bring their child to Stratford.

Many of the parents would have liked to have been warned about the drawbacks of residential treatment. One parent gave the example of receiving letters from her son that were full of negative comments. If she had been told to expect these negative letters she would not have felt such panic upon receiving them. One parent would have liked to have been warned how long her son would be in treatment.

One of the divorced parents was unhappy because they were not invited to the pre-visit. She reported that the other set of parents used the pre-visit as an opportunity to say negative things about her to the cottage staff. Consequently, she felt as if she "got off on the wrong foot" and it was difficult for her to work with Stratford's staff.
The Professionals' Response

In March of 1994, the researcher learned that 3 months after the collection of data, the state had changed the method for funding residential treatment facilities. In addition, the state had adopted new standards to regulate how residential treatment facilities interact with families. At the heart of these changes was a move towards more involvement of the family in the treatment process. Consequently, some of the informant-parents' concerns had already been addressed by the state's change in policy.

The professionals welcomed the opportunity to respond to the perceptions of the parents. The domains that emerged from their responses were: historically this has worked for us; time and/or money constraints impact how and what services are offered; state regulations dictate how this is done; and we never thought of that before. The professionals' responses are presented in relationship to the domains generated from the focus groups.

Imposed domains

Domain: Quarterly staffings. The Department of Human Services (DHS) has required that a staffing be conducted on a child every 90 days. The DHS required the presence of a representative of the treatment facility and the child's case worker at the staffing. Several years ago Stratford made the
decision that it was important to involve the family in the child's treatment. The quarterly staffing was redesigned to include the child and the family in order to keep them updated on the child's progress and include them in discussions about the child's future.

The professionals agreed it would be best if all of the professionals who worked with a child attended the staffings. However, the director recognized that due to time constraints it would not be feasible for all of the staff to attend every staffing.

Every professional who worked with a child wrote a report describing their contact with the child during the last 90 days. These reports are forwarded to the DHS. Stratford does not send the family a copy of the quarterly report, because they believe that it would not be helpful for the family to read the diagnosis and labels without a professional there to assist them.

Parents were frustrated because they were not always consulted in the setting of a date and time of each staffing. The director was concerned about the parents' frustration, but staffings must be held during regular business hours to enable the DHS and Stratford Homes staff to attend.
Domain: Home visits. On this issue, the director felt in a bind. On one hand, home visits are viewed as a continuation of treatment and are an excellent opportunity to gauge the progress of the child and the family. On the other hand, Stratford has been paid a daily rate by the DHS for the care of a child and are under an obligation to justify this payment. To justify payment from the DHS and provide the child with the opportunity to be with the family Stratford Homes established a procedure whereby the DHS referring worker approves the child's home visit. This kept the DHS informed and allowed the child home visits with his/her family.

The home visit form has a place for the cottage staff to write in specific goals for the child which answered the parents' concern that the home visit forms should be tailored to the specific needs of the child. It may be that staff are not completing the forms correctly.

Although parents may not be satisfied with the form, past experience has taught the professionals the value of structure in dealing with parents. Some parents are similar to their children in that they prefer no structure, yet do not perform well without structure. The director was quick to add that not all parents behave in that way, but in order to maintain consistency, structure is maintained with all parents on all home visits.
Domain: Phase promotions. No one at Stratford had ever thought of involving the parents in the phase promotion process until the researcher reported the suggestion of the parents. They were also receptive to the notion that parents would serve as excellent motivators for the children. In both cases the staff thought the ideas had merit and were anxious to include them in the treatment process.

Domain: Advice to parents. The campus director was intrigued by a parent's comment that parents need to "learn how to play the professional's game." She reframed this as "learning how to work within the system."

The treatment program at Stratford was very structured and the residents and their families were expected to stay within this structure regarding home visits, campus visits, phone calls, and letter writing. By providing and enforcing structure, the staff taught the residents that society has rules and that it is important to live your life within those rules.

The need of the residents to learn how to work within the system was isomorphic to the need of the parents to learn how to operate within the system. By imposing structure on the parents as well as the residents, parents will learn with their child how to work more effectively with other systems.
Domain: Advice to professionals. The director agreed with the parents that each child was unique and has different needs. She also supported their contention that it was not helpful for the child, or the parents, to hear a label and/or a diagnosis attached to a child. The unwritten Stratford Homes policy was to limit the use of labels and/or diagnoses to conversations between professionals and for use in official documents between agencies. A favorite Stratford phrase was "to label is to disable".

Stratford has to use labels for the larger mental health system. The DHS, and other mental health agencies, use labels as shorthand form of communication. In other words, rather than list multiple symptoms, a label, usually one to three words, is used instead. Even though the staff at Stratford may not "believe" in the label, the larger mental health system requires the use of labels.

When told of the parents' frustration about not feeling heard by the professionals, the director commented that things have changed in that area. Earlier reports by the researcher to the staff about what the parents were saying had convinced the director that change was needed in this area. There has been an emphasis on helping the on-line workers make this switch by talking about the parents as experts in support meetings and at the quarterly staffings.
Domain: Family therapy. The desire for the therapist to be more assertive about what issues were discussed and who should attend the sessions was not congruent with the current thinking in the field. The family therapists had been using a collaborative approach as articulated by Goolishian and Anderson (1990). This approach stressed the need for the therapist and family to co-create the therapeutic process. In a residential setting the collaborative approach was implemented by talking with the resident and involved family members to determine the direction of therapy. The parents' assertion that a collaborative approach gave too much influence to the child and not enough to the family was noted. Basically, the family therapists had not considered therapy from this perspective.

Another issue the parents brought to the attention of the family therapists was the need to place more emphasis on issues about divorce. The explanation provided by the family therapist about why this occurred goes back to the writings of Goolishian and Anderson as discussed in the previous paragraph. The therapist had attempted to work with the family to determine the issues to discuss in therapy. If the issue of divorce was not raised by the resident or a family member the therapist respected the family's wish to not discuss it.
Domain: Contact with other parents. The director found this information especially helpful because, in essence, the professionals were providing a support group and calling it multifamily therapy. The staff were open to changing the name of the group if that would make it less threatening and more attractive to parents.

Emergent domains

Domain: Involvement in treatment. Like the parents, the professionals viewed this as a problem area with no simple solution. The director identified barriers to involving the family and programs/methods Stratford had incorporated in its attempt to overcome the barriers.

The difficulty of involving families in treatment stemmed from the focus the mental health system has historically placed on the child. The system identified the child as the client, therefore the treatment center's goals and objectives should reflect the child's needs. The Diagnostic and Statistical Manual of Mental Disorders (third Edition-Revised) or DSM III-R, has no diagnoses for families, just individuals. The child in placement had to have a diagnosis, therefore the system defined the child, not the family, as the problem.

Another barrier confronting the treatment facility concerned how to motivate the resident to change. Past experience had taught Stratford that the best way to motivate
the resident is to have the resident share ownership in the treatment goals. When the resident and parents have similar goals, both are satisfied with the goals. When there are differences between the goals of the parents and the resident, Stratford Homes has historically let the child have the final say.

To overcome the parents' lack of involvement in treatment, Stratford incorporated family therapy as an intrinsic part of treatment and started inviting the parents to participate in the quarterly staffings. This has not solved the problem, but it has helped. The director was open to suggestions that will give the parents more involvement.

When the researcher read quotations from parents about how they felt like outsiders and were told by staff that they were to blame for their child's problems, she was quite upset. She reported that theoretically Stratford had adopted a family-centered approach to treatment several years ago. They were still in the process of implementing family-centered ideas into all aspects of care. The director concluded that there was still work to be done in this area.

Domain: Triangulation by adolescents. The professional staff were aware of this problem and willing to accept a portion of the blame. When a parent brings this behavior to the attention of a staff member they attempt to deal with it
immediately. The situation becomes more difficult if Stratford Homes decides not to accept the parent's advice regarding the situation. Then the parent feels invalidated and unheard. When asked to give a situation where the parent's advice would not be acted upon the response was: when the child's safety was in question; the parent did not seem truthful; and when there were cottage and/or other dynamics which made it difficult to give the parent what they wanted.

**Domain: Sharing information.** The staff shared as much helpful information with the parents as the parents were willing to hear. The information contained in the quarterly staffings was not shared with the parents because it contained labels and other language which could create additional problems for the family.

In the past there were times when someone (e.g. Stratford staff, DHS worker) told a resident a label that the professionals used to describe their behavior. The resident took this information and either used it as an excuse for inappropriate behavior and/or found the label so discouraging that the resident found it much more difficult to change his/her behavior. Consequently, the staff has been reluctant to share that kind of information with the family.

In addition, since the data were collected for the study, Stratford has implemented new policies which increase the
family's involvement regarding treatment plans and information on the child's behavior. This change was consistent with Stratford's quest to have a family-centered treatment process.

Domain: Families with divorce. Like the researcher, the professional staff were amazed at all of the treatment issues that were impacted by the presence of a divorce in the resident's family. The director said that she had not been aware of all the issues that were generated by the study and thought that being aware of them would be helpful.

The director agreed with the notion, although it may be a bit simplistic, that the parent who talks the loudest and most does get heard. For the staff it is either "we work with the parent(s) that communicate with us" or "the squeaky wheel gets the grease." It is sometimes difficult to differentiate between the two.

Domain: Making decisions. The Stratford staff agreed with the parents that the treatment staff have the final say on most issues. The staff are also aware of how frustrating this can be for parents and residents.

The staff at Stratford thought that it was important for them to be consistent with the residents and families. The director acknowledged that sometimes the best group decision
was not the best individual decision and was open to the comments of the parents.

The Stratford staff do not make decisions in order to punish parents, however the actions of a parent do have consequences and the parent may perceive those consequences as punishment. For example, if a parent failed to provide supervision of a child on a home visit and the child got into trouble, the child may lose their next home visit. This action was not designed to punish the parents, rather it is meant to hold them responsible and to teach them the importance of providing supervision and the need to follow through with their commitments.

Domain: Getting to know the family. The family therapist at Stratford used to visit the home of every Stratford resident within the first few months of their placement. This practice was viewed as helpful to the treatment team and the parents appreciated the visits. The practice was discontinued several years ago because it was too expensive and required too much time away from other duties. This is a practice that Stratford would like to begin again, provided that they can find a funding source.
Domain: Pre-visit. The staff were happy to hear that the pre visits were helpful and plan to continue this practice. There was a discussion about having parents attend a parent orientation meeting within the first 90 days of a child's placement. This meeting would focus on informing the parents about Stratford's treatment philosophy, the phase and level system, rules and the reason behind the rules, and to provide the parents with the opportunity to ask questions and/or express their concerns to the treatment staff.

Parent Questionnaire

Questionnaires were given to all of the parents before they participated in a focus group. The questionnaires (Appendix C) served as a member check of the focus group data. This section will contain the mean, median, and mode of each question and a comparison of the questionnaire data and the focus group data.

<table>
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<th>NOT AT ALL</th>
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1. Program staff were sensitive to my family's concerns about privacy.

mean=5 median=5 mode=5 range=3-6
2. Family members and anyone else that I want to be involved in treatment was included by the staff.
   mean=5   median=5   mode=5   range=2-6

3. The staff took my comments and concerns seriously.
   mean=5   median=6   mode=6   range=3-6

4. The staff were non-judgmental and respected what was important to my family.
   mean=5   median=5   mode=6   range=1-6

5. The staff used language that was understandable to me.
   mean=5   median=5   mode=5   range=4-6

6. The staff were aware of our family's strength.
   mean=5   median=5   mode=5   range=2-6

7. My adolescent's strengths were considered in developing a treatment plan.
   mean=5   median=5   mode=5   range=2-6

8. Most of our family's major concerns were addressed in treatment.
   mean=5   median=5   mode=5   range=2-6

9. The staff were sensitive to the family's schedule when scheduling meetings.
   mean=5   median=6   mode=6   range=3-6

10. The staff were honest with information and provided it an open and supportive manner.
    mean=5   median=5   mode=6   range=2-6

11. The staff communicated with me in a respectful manner.
Regarding questions 1, 4, 5, 6, 7, 10, and 11, the responses in the questionnaire were congruent with the comments of the focus group participants. The responses to questions 2, 3, 8, 9, and 12 did not match the comments voiced by the parents during the focus groups. During the member checks conducted on the telephone, the informants were asked to explain the differences. The parents said that overall they were satisfied with the treatment program at Stratford Homes and did not see a discrepancy between the verbal and written responses. One informant said, "Don't change the overall program, because of what we said, just improve the communication and some other minor points."

**Summary**

This chapter presented the qualitative results of the focus groups, the professionals' responses, and the findings from the parent questionnaire. The next chapter discusses the tentative conclusions from the study and the implications for additional research.
CHAPTER 5
DISCUSSION

This qualitative study examined family-based descriptions of having a child in Stratford's residential treatment program. Families' descriptions of the treatment process were collected through four moderately structured focus groups. The transcripts from the focus groups were analyzed to develop an initial ethnographic account of Stratford's residential program as described by parents who had a child in the program.

The previous chapters presented the relevant clinical and theoretical literature for the study, the methodology used in the study, and the results of the study. This chapter contains a summary of the findings, a discussion relating these findings to findings of previous research, two theoretical explanations for the interaction between the treatment staff and the families, and solutions for the "friction" between the staff and parents. In addition, conclusions are drawn with recommendations for future research and a summary of the research project are also presented in this chapter.
Summary of Results

Qualitative results were presented in their entirety in the results chapter. A concise version of the domains has been presented below.

1. There was concern about the scheduling, length, frequency, and the notification procedure of the staffings. Most parents reported that all of the professionals who worked with their children should attend the staffings. This would give them a better picture of the child's progress. Many of the parents were satisfied with the agenda and focus of the staffings. Staffings provided an opportunity for the parents to hear about the day-to-day activities of the child. Parents also reported that the quarterly staffings were important because it gave them access to the professionals who worked with their child.

2. All of the parents would have liked having their child home more. A frequent complaint focused on the home visit forms which had to be completed for every visit. Parents suggested that the forms should be individualized for the child, more than yes/no responses, and the staff should respond to the feedback on the forms. Most parents did not like having a home visit canceled without a chance to provide input on that decision. It was especially frustrating to have a visit denied because of a peer's misbehavior.
3. Nearly all of the parents wanted more information describing the different phases, the goals of each phase, and what the child needed to accomplish to be promoted from a phase. If the parents had this information they thought they would be able to keep pressure on their child to complete the work required of each phase. Parents also would have liked to have been involved in the discussion regarding phase promotions.

4. The most repeated advice to other parents was on how to work with the professionals. Parents suggested that parents should know the goals and expectations the professionals had for their children. There was a warning to not appear too pushy, but rather to learn how to play the professionals' game. Most parents advised involvement in their child's treatment. It was also said that treatment may be difficult, but at the end it would be worth it.

5. Most parents also wanted the professionals to be aware of how difficult it was to leave the responsibility of caring for and protecting their child to someone else. It was also important that the professionals listen to their input. Many of the parents reported being frustrated when their observations and comments were ignored. Parents wanted the professionals to be aware of the individual characteristics of each child. Many of the parents did not like the professionals generalizing about and/or labeling their child.
6. All of the parents reported that family therapy was an important part of their children's treatment. Most parents thought that the therapist needed to be more assertive regarding who should attend sessions and what the family discussed. Therapy was a forum where they could discuss upcoming home visits, the child's return to the home, and problems with the cottage staff. Many parents wanted family therapy to play a bigger role in working on issues surrounding divorce. Some parents suggested that family therapy would be a good place to work out differences between parents as well as between the parents and the child. Many parents wanted family therapy to be available to them after the child was discharged from Stratford Homes.

7. Nearly all of the parents reported that they would have been involved in a parent support group if one had been available. Most of them were not interested in being a part of a multifamily therapy session where they would have to share their family's problems with others. They preferred a group where they could get support and parenting tips from other parents.

8. Without exception the parents reported that they wanted to be more involved in the treatment process. The main area they desired more involvement in was in the setting and achieving of goals. Most of the parents reported that they felt like outsiders. It confused the parents to have a goal
of family reunification and to be treated like outsiders. A
staff member told one parent that Stratford felt more
comfortable working with under-involved parents as opposed to
parents who wanted to be involved.

9. A common observation by parents was that residents
were able to pit parents and staff against each other and/or
staff against staff. The parents viewed this as a
continuation of the behavior which got the child placed in
Stratford Homes and were frustrated when it was permitted to
continue. This seemed to occur more often in families where
there was divorce. Some of the suggestions for blocking
triangulation by adolescents were individual counseling
sessions, more direct communication between adults, and for
the staff to listen to the parents warnings.

10. All of the parents thought they should have received
more information from the Stratford Homes staff. The amount
of additional information they wanted varied greatly. Parents
thought that Stratford did a good job of handling the day-to-
day activities but they still wanted more information on day-
to-day activities and important issues such as academic and
health issues. Most parents reported that if they wanted the
cottage staff to have information they had to volunteer it
because the staff did not ask them for any information. The
parents were much more comfortable talking with professionals
as opposed to corresponding by letter.
11. Issues surrounding working with families with divorce were often clouded with emotions. Nearly all of the divorced parents interviewed felt that at some point the other parent received better treatment than they. There were complaints that the information shared by the staff with parents was not always consistent, that staff actively and/or passively took sides, that there were inconsistencies with frequency and/or length of home visits. There were also concerns that the child went through the treatment process without adequately addressing the issues with their parents about the divorce. In addition, some parents complained that staff did not offer parents a chance to work out their differences and others complained that the staff tried to force divorced parents to work out their differences.

12. Nearly all of the parents thought the cottage acted like they had the final say on all decisions. Some of the parents reported feeling as if they were being punished for not being good parents. The parents were particularly frustrated when the adolescent was able to choose which topics would be addressed in treatment. Several of the parents reported a desire to be involved in the making of decisions so they could learn from Stratford on how to make good choices.

13. Parents were pleased when they had the opportunity to meet individually with residential counselors and/or social workers. Most of the parents viewed these people as the
"hands on" workers and thought they had the most accurate information about their child. Several of the parents thought it would be helpful for the cottage staff to visit their home. They thought this would give the staff a better picture of their family. Most of the parents thought it was helpful to be on friendly terms with the cottage staff and were uncomfortable when that did not occur.

14. All of the parents who attended a pre-visit reported that it was very helpful. The parents appreciated the opportunity to see the facilities and to meet the professionals who would work with their child. The parents thought it was a good way to get an overview of how Stratford Homes worked. The parents who did not attend a pre-visit thought attending one might have made the first 30 days a little easier. However, some parents reported that the referring worker and/or other parents used the pre-visit as a time to set the staff against them.

Elaboration of Results

The present study examined family-based descriptions of having a child in Stratford's residential treatment program. Specifically, transcripts of moderately structured focus groups were examined to collect qualitative data regarding:

1. From the family's point of view, what has been helpful or not helpful about Stratford Homes' treatment process?
2. How, if at all, has the family felt it was a part of the treatment process?

3. In which of the following areas would the family have liked to have been involved?
   - Parent discussion groups
   - Parent education/training
   - Involvement in cottage life
   - The setting of goals
   - Phase promotions for the adolescent
   - Knowledge involved in phase promotion
   - Involvement in promotion process

4. From the family's point of view, what role has family therapy had in the treatment process?

5. From the family's point of view, how could the effectiveness of family therapy have been increased?

6. What advice have families for parents who are just beginning to work with Stratford Homes?

7. What advice have families for professionals who work with families at Stratford?

   One of the most striking results of the study was the desire of families to be more involved in the treatment process. The areas in which they wanted to be involved and the level of that involvement varied from parent to parent, but all of the parents expressed a desire to be more involved. The need for parental involvement has long been recognized in
the field of residential treatment (Gordon, 1971; Patterson, Cobb & Ray, 1972; Taylor & Alpert, 1973; Wilson & Lyman, 1983). The problem has been that the professionals, not the families, have defined the areas for family involvement. In the past professionals, intentionally or unintentionally, kept themselves as the experts by limiting family involvement to areas where the family was the client, i.e., support groups, parent educational groups, family therapy (Gordon, 1971). The parents in this study wanted to expand their involvement from being clients to also being experts.

The idea that a parent can be both client and expert is consistent with the family-centered practice in the field of early intervention (Dunst, Trivette, & Deal, 1988; Krauss, 1990; McBride, Brotherson, Joanning, Whiddon & Demmitt, 1993) and the field of family therapy (Keeney, 1983; Watzlawick, Bavelas, & Jackson, 1967). Although the parents did not use the term family-guided, they indicated that it would be helpful if those involved in residential treatment were able to make the shift to what the literature describes as family-guided services (McBride et al., 1993).

These parents would have liked more involvement in the making of decisions. Specifically, parents wanted more influence on the goals that were set for their child, the amount of contact they had with their child, and what information was provided to the professionals about their
child. One parent saw the Stratford staff as having the attitude that "we've got him instead of you and you are on the sidelines." Unlike the quotation suggests, the parents in this study were not looking at residential treatment as a method to avoid the child and their responsibilities. Rather, the parents wanted to stay involved with their child and have input in the child's treatment.

None of the parents reported satisfaction with their level of involvement in the setting of their child's treatment goals. In fact, the majority of parents had no input on the goals that were set for their child. Parents would have liked a meeting with the professionals to state what issues they wanted addressed in treatment and how best to address those issues. Parents reported that by not being involved in setting the treatment agenda some very important issues were not addressed. As one parent reported, "Nothing has ever been resolved with us. We feel like now we don't have the opportunity to get into this in family therapy."

Consequently, those unaddressed issues were still a problem.

Most of the parents were satisfied with their level of involvement in the day-to-day issues of treatment. They appreciated the comments by the staff and felt like part of the team when the social workers and residential counselors shared treatment information with them. This is consistent with other literature which stressed the importance of having
the parents see themselves as "partners" in the treatment process (Pitsch, 1992).

The parents in this study wanted to be more than just "partners" on issues of knowing their child. Nearly all of the parents reported that there were times when they tried to provide information and/or insight into their child's behavior and were ignored. One parent told the cottage staff "I know ________ is conning you. I would get the feeling of oh, you just don't like him. You are making this up." Other parents told of similar occurrences. In the area of knowing their child the parents want to be seen as the experts. The researcher was unable to find literature in the field of residential treatment which supported the value of elevating parents as experts on their children.

This study has indicated that instead of viewing parents as either experts or partners it would be more appropriate to view them as experts and partners. These data suggest that the parents want the Stratford staff to take the lead and let them be partners on issues involving the child's peers and interaction with staff. On issues that involve the child's past, future, and family the parents want to be viewed as the experts. As one parent put it, "remember that the parents know the child better than you."

Another striking finding of the study was how the presence of a divorce impacts the treatment process. From the
professionals vantage point, Weisfeld and Laser (1977), divorce impacts the child's treatment regarding trust issues, triangulation of the child by parents, and the child's uncertainty surrounding what caused the divorce. From the parents' perspective there are issues involving where the child will spend home visits, the setting of treatment goals, and how much contact will the child have with the other parent. Based on the information from this study, the primary concern of divorced parents is "who will the staff believe?". The parents viewed the staff at Stratford Homes as having a great deal of influence regarding where the child would live after they were discharged from the group home. Consequently, the parents were concerned when they sensed the staff were taking the side of the other parent, not believing them, believing inaccurate information from the other parents, and/or viewing them as the problem parent.

Another treatment issue for some divorced parents was how to be involved in the child's treatment and simultaneously avoid the other parent. There were parents who avoided the quarterly staffings and family therapy with the other parents because they found it so difficult to be in the presence of the other parent. For some parents this created a great deal of anxiety because it stifled their involvement with the child and they thought it might reflect poorly on them.
As expected, parents experienced family therapy as a useful part of the treatment process. The families in the study supported the findings of previous research and cited family therapy as a useful method for dealing with family problems and for preparing them for the child's transition back into the home (Koret, 1973; Millard & McLagen, 1972; Weisfeld & Laser, 1977).

One of the major uses of family therapy was as a forum to discuss cottage policy and politics. Several of the parents reported that the family therapist helped them to understand how the cottages worked and the reasons behind the rules. In addition, family therapy was a place for the parents to vent their frustrations without fear of reprisal. This idea of the family therapist working with the larger system is not new to the literature (Anderson & Goolishian, 1986), yet has not been applied to the field of residential treatment.

Some of the parents reported that the family therapist should provide more structure regarding who attends the sessions and what was discussed. This is consistent with the growing body of evidence suggesting that the early stages of therapy are viewed as being more effective when the therapist imposes a sense of structure (Gurman, Kniskern, & Pinsof, 1986). Research also indicates that therapist intervention and the provision of structure were positively related to improvement in the client (Green & Herget, 1991).
The majority of the parents reported that the first few months of treatment were the most difficult. This finding is congruent with studies on how the placement impacts the adolescent. Gispert, Wheeler, Marsh, and Davis (1985) and Levine (1988) wrote about the psychological turmoil the adolescent experiences when first removed from the home. According to the data collected in this study, parents have a similar experience. Parents felt like they had failed as parents and were being punished for their child's actions. They were concerned about their child's safety, and they did not like being isolated from the child.

Parents often made comments about how the child pitted the parents and staff against each other. The literature (Madanes, 1980; Pitsch, 1992; Weisfeld & Laser, 1977) discussed how the child was impacted by the arguments with no comment on how this impacted the parents. In this study, the parents reported that this retarded the treatment process by allowing the child to avoid issues, manipulate situations to their advantage, and avoid being honest with themselves and adults.

Parents thought the opportunity for adolescents to pit adult against adult would be eliminated by involving parents more in the treatment process. In this case, involvement would mean more communication between parents and staff. One parent commented that communication "needs to be a complete
circle, not kids here and people over there. Here's the parents and here's the worker...We(parents) know what is going on here(home), but if none of this input gets back over here(cottage), if that kid isn't strong enough to go ahead (and tell) you are going to be sitting there (in treatment) a long time." The parents said that issues could be dealt with more quickly and more efficiently by communicating with the parents on a consistent and open manner.

**Theoretical Explanations**

This section provides two theoretical explanations for the interaction between the treatment staff and the families. Murray Bowen's Family Systems Theory and Interactional Theory, as articulated by Don Jackson, will be used to describe this process. The theories of Jackson and Bowen reflect the "new" ideas which emerged from systems theory in the 1950's. Bowen (1990) wrote:

Jackson and I were the only two from the original family researchers with a significant interest in theory. Jackson's group included Bateson, Haley, and Weakland. They began with a simple communication model of human relationships, but soon expanded the concept to include the total of human interaction in the concept. By the time Jackson died in 1968, he had moved toward a rather sophisticated systems model. I believe my theory had a
sounder base to connect it with an instinctual motor; Jackson was operating more on phenomenology, but he was moving toward a distinctly different theory. (p. 352)

Family Systems Theory

Murray Bowen developed this theory to explain the interaction in families with a schizophrenic member. In the 1970's he used these ideas to explain the organization and interaction of the work place, social organizations, and society in general.

This theory centered around two sets of opposing forces: those that bind personalities in the family together, and those that fight to break free toward individuality. The central premise was that unresolved emotional attachment to one's family must be resolved, rather than passively accepted or reactively rejected. This allowed an individual to differentiate into a mature and healthy personality (Bowen, 1990).

In Bowen's Family Systems Theory a well-adjusted family/system had the following characteristics: 1) They were balanced and can adapt to change; 2) emotional problems were seen as existing in the whole group; 3) they were connected across generations to all family members; 4) they used a minimum of fusion and a minimum of distance to solve problems; 5) each dyad dealt with problems between them; 6) differences
were tolerated; 7) each person dealt on thinking and emotional levels with the others; 8) they were aware of what each person got from within and from others; 9) each person was allowed his or her own emptiness; 10) preservation of positive emotional environment were more important than being "right"; 11) each member thought it's a good family in which to live; and 12) members of the family used each other as sources of strength, not as an emotional crutch (Fogarty, 1976).

As a family therapist at Stratford Homes, the researcher observed that the majority of parents and children involved in treatment had low levels of differentiation. It was very difficult for them to separate their emotional and intellectual systems. The emotional reactivity present in the parent-child relationships was isomorphic to the parent-staff and staff-children relationships.

The high level of enmeshment present in the parent-child relationship explained why it was so difficult for the parents to allow the treatment staff to do their job. A common occurrence was for the parents to initially support the placement of their child into the residential treatment center. The parents recognized that the child had not made useful choices and that a change was needed. At that time the parents generally supported the staff and what they were trying to accomplish.
A shift occurred in the parent-child relationship early in the treatment process. Initially the parents were holding the child responsible for their choices, they were voicing a need for the child to change, and were aware of the child's "flaws." The child had reported to the parents the difficulties of being in treatment and the staff have been pointing out the "flaws" that earlier the parents were pointing out to the staff.

The parents began the treatment process with the conviction that there were problems in the family and they were going to deal with those problems. Their resolve for change goes down as their sense of guilt increases. The guilt comes from a number of sources: The child's complaints about being treated unfairly and isolated from the family; the extended family who have been telling them how they "should" handle the situation; and if the child's parents were divorced, the non-custodial parent usually did not support the placement of the child into a residential treatment center. Soon the parent's sense of "loyalty" came into play. Even though they were cognitively aware of what needed to be done, emotionally the parents could not bring themselves to act on what they knew was the best course of action.

The parents had begun the shift from demanding that the child make changes to demanding that the staff change to accommodate the child. Instead of demanding that the child
followed rules and participated in treatment, they had begun to question the rules and make excuses for the child's behavior. The parents changed their focus from the child and how he/she was behaving to the staff and how they were treating the child.

According to Bowen (1990), people at the low end of the differentiation scale based choices on their emotional process and by what "feels right", rather than by beliefs or opinions. Over time the parents' anger at the child subsided and they missed the regular contact with their child. The parents had changed their focus from the child's participation in treatment to how they could get the child back home. The parents had begun to view the child and themselves as "victims" of the system rather than as part of the system. Their language changed from "accomplish your goals so that you can return home" to "when are you (the staff) going to quit jerking my child around and let him/her return home?" The parents did not perceive the locus of control as belonging to them. Instead, they felt that it belonged to someone they could not influence or impact. They were pawns in someone's game.

When the focus of the parents centered on the treatment staff instead of on the child, treatment quickly ground to a stop. In order for the child to remain loyal to the family he/she had to accept the family's view that the professionals
were wrong and the family was right. Deviating from this stance was unacceptable (Bowen, 1990).

If the family's lack of differentiation was manifested by cutting off their relationship with the child, the child may commit to treatment after the family has disengaged from treatment. When this occurred, the child often gained a high status with the cottage staff because he/she was siding with the staff against the "bad" parents. Whether the family were disengaged or enmeshed, there were good guys and bad guys and the focus of treatment was defining who was good and who was bad rather than on change.

Interactional Theory

Don Jackson wrote that any belief shared by members of a group constitutes the reality they experience (Bateson & Jackson, 1968; Jackson, 1965a; Jackson, 1965b). Rather than leave the idea at a theoretical level Jackson believed that reality was created phenomenologically (Jackson, 1965a).

According to Jackson, reality occurred as the participants in a relationship acted in ways to define the nature of the relationship. All behavior had message value and therefore was viewed as communication. Since there was no such thing as non-behavior, the defining of the relationship could not not occur (Watzlawick, Bavelas, & Jackson, 1967). In every communication the participants offered to each other
definitions of their relationship in an effort to determine the nature of the relationship. One participant responded to the other participant with his/her definition of the relationship which may affirm, deny or modify the definition the other participant had for the relationship (Jackson, 1965b). This process defined certain behaviors as acceptable while other behaviors were excluded from the relationship. Thus, observable communication patterns emerged between the participants. These patterns could be metaphorically understood as the rules that governed the relationship (Jackson, 1965a). The more rigid and restrictive the rules of the relationship the less adaptive the family was to change and the more likely that a family member would be identified as "symptomatic" (Jackson, 1967). The focus of therapy was the patterns which connected family members.

A re-occurring pattern between cottage staff and parents centered on the question, "who has the problem?". The answer defined who was the client, the child or the family, and what were the goals, family goals or child goals. When the parents and staff were in agreement on this issue the relationship could be described as a complementary one. In a complementary relationship the behavior of one participant complemented the behavior of the other (Watzlawick et al., 1967). In this case both "sides" were satisfied with how the relationship had been defined. When the parties disagreed on "who has the problem", 

the relationship could be viewed as a symmetrical one. In a symmetrical relationship the partners tended to mirror the behavior of the other (Watzlawick et al., 1967). In this case, neither the cottage staff nor the family were satisfied with how the problem had been defined and were attempting to re-define it.

The researcher observed that one of four patterns emerged around the question of who had the problem. In the first scenario, the staff defined the problem as a family problem and the family defined the problem as a family problem. In this case the relationship was a complementary one with the participants satisfied with how they were viewed by the other. In this scenario the participants were able to focus on solving the problem and were usually successful.

In the second scenario, the staff defined the child as the problem and the family defined the child as the problem. As in the previous scenario the participants were in a complementary relationship about who had the problem. As in the previous scenario the participants were able to focus their energy on finding a solution to the child's problem.

In the third scenario, the staff defined the family as the problem and the family defined the child as the problem. In this symmetrical relationship a pattern emerged with the participants focused on convincing the other participants to see the problem their way. In these cases it was very
difficult for treatment to occur because the participants were not in agreement about who to treat. Rather than the parents and staff working together, each side was focused on convincing the other about who was "right" and who was "wrong." When this pattern emerged, the participants were easily drawn into triangulations and/or attempted to withdraw from the relationship.

In the fourth scenario, the staff defined the child as the problem and the family defined the family as the problem. As in the previous symmetrical relationship, the participants spent their time re-defining who was the problem instead of being focused on solutions.

The struggle about who was the problem does not always occur between the staff and the family. The four scenarios were played out between staff members and/or family members as well. At the staff level the struggle usually occurred between the residential counselors and the support staff. At the family level the disagreement occurred between the mother and father and/or between the parents and the child. The disagreement about who was the problem could be especially intense in a family with divorce. In these cases, questions regarding treatment became a part of the on-going battle/pattern of who was at fault in the divorce.

Agreement on "who is the problem" does not always mean that the parties were in agreement on the solution. In a
complementary relationship the family was defined as the experts on the family’s history and future. In other words, the staff saw the parents as “knowing” the child better than they. The staff listened to the suggestions and observations of the parents about how the past and future were impacting the present. In a complementary relationship the parents viewed the staff as the experts on how to facilitate the desired change. The parents were open to the staff’s observations and suggestions about how treatment should be conducted.

In a symmetrical relationship the participants were not in agreement on the rules of the relationship. The staff were unwilling to accept the parent’s assertion that they were the experts on their child. Likewise, the parents were unwilling to accept the idea that the staff were the experts in creating change. Rather than be focused on solutions the participants were focused on convincing the others to accept their view of the relationship. This was done by arguing, consulting other professionals and/or family members, sabotaging the work of the others, and/or withdrawing from the relationship.

Solutions

This section provides solutions for professionals who work with families in a residential setting. The solutions offered are both theoretical and practical.
According to Bowen (1990), the best way to decrease the friction between systems was to increase the level of differentiation of the participants in the systems. At a treatment level this impacts how the professionals interact with the families and it provides a theoretical framework for "teaching" individuals/families how to act in a differentiated fashion.

The techniques that Bowen articulated to assist in the differentiation process apply to both the families and the professionals. In other words, the principles could be taught to the residents, parents, and treatment staff. The format for discussing the principles with the family could involve parenting groups, individual therapy, and/or family sessions. For the professionals, this training could occur in individual sessions and/or seminars. An interesting twist to the teaching process would be to have residents, families, and professionals "learn" these concepts together. This would provide an interesting, although possibly threatening, forum for immediate application.

In the context of Interactional Theory, the solution for improving the interaction between the staff and parents is for the treatment staff to move from a simple cybernetic model to a cybernetics of cybernetics model. Harry Stack Sullivan (1938), the forerunner of Interactional Theory, wrote
Human behavior, including the verbal report of subjective appearances (phenomena), is the actual matter of observation of the psychiatrist; it is important, however, to note that the act of observing is itself human behavior and involves the observer's experience.

(p. 122)

By adopting a cybernetics of cybernetics view, the treatment staff would be aware of how they participate in their conflicts with parents and of how they participate in the four scenarios discussed earlier in the Interaction Theory section of this chapter. Awareness of their participation means the staff would be able to change their participation. Rather than placing the blame on the parents, the staff could accept partial responsibility for the conflict and develop new methods for intervening in the conflict.

There is some common ground between a cybernetics of cybernetics approach and Bowen's differentiation techniques. Both approaches rely on the participants' abilities to "step outside" an interaction to see their role in the interaction process.

Conclusions

The relatively small sample size of parents may limit the transferability of some of these findings. Nevertheless, the findings supported the notion that families desire services in
which they could be involved. The motivations for being involved ranged from a recognition that the child's behavior was a reflection of a family problem to the belief that nobody knows and/or was more concerned about a child than the child's parent.

The clear message from parents was that they knew their child better than the professionals. Although it was not articulated that specifically, the implication was that they knew when the child was being untruthful, they knew the family secrets, they were aware of the people, places, and things the child had been exposed to, the parents knew where the child had been and to what type of environment the child would return. With all of this valuable information the parents did not understand why their comments and suggestions were not taken more seriously.

The data also suggested that parents would like a great deal more communication between the staff and themselves. Although a few of the parents said they were satisfied with the information they received from Stratford Homes, the vast majority of the parents were not satisfied. A re-occurring comment was that if you wanted the staff to be aware of something you better tell them because they would not ask. Several parents also commented that the only way to find out how things were going with their child was to call the cottage
because the cottage never called parents and volunteered information.

Data from the study suggested that families with divorce had more and/or different issues than families in which there was no divorce. In this situation the treatment staff were often watched closely by the parents to determine if they were showing favoritism and/or taking sides. In addition, it was much more difficult for the treatment staff and the parents to work together as a team because of unsettled issues between the divorced parents. In these situations it was also much easier for the adolescent to pit adults against each other.

The data also confirmed the importance of the first months of the treatment process. Several of the parents commented on how helpful the pre-visit was to them. Many of the parents would have liked more information at that time. Parents thought that would have been a good time to have received information about the phase promotions, cottage rules, and the goals behind the rules.

Overall, the results of the study should remind professionals that families want to be involved in the treatment of the child. Parents did not approach residential treatment as a break from their child, rather, it was seen as an opportunity to deal with important issues. Professionals, on the other hand, viewed the parents as dumping the children off to be fixed and then returning when the job had been
completed. The incongruent views about how professionals viewed parents and how parents viewed themselves created a great deal of frustration for the parents and for the professionals. Since family reunification was the goal of all the parents in the study every goal, home visit, and family therapy sessions should focus on that objective.

**Recommendations for Future Research**

This study began the process of collecting information about residential treatment from the families' perspective. There are still many areas within the field of residential treatment which need to be explored. Future research could focus on particular phases of treatment, specific populations, different problems, and on gender and/or age specific populations. In essence, it is an under-explored perspective.

In addition to exploring other treatment areas from the perspective of the family, there is also a need to study different residential treatment models from the families' perspective. Stratford Homes' approach is typical of most residential treatment facilities, but it would be helpful to conduct studies involving parents from other facilities.

The sample in this study was diverse in terms of socio-economic levels, family structure, gender, and age, but, the sample was predominately white, all of whom resided in the
midwest. There is a need to conduct similar research with families from other races and different geographic regions.

The method for collecting data in this study was focus groups. It would be helpful to see whether similar data could be collected using ethnographic interviews. The complete confidentiality of the one-on-one interview may help some parents be more forthcoming with their opinions. In addition, the ethnographic interviewer can take the time to focus on an individual's concerns without the fear of losing the participation of the other group members.

This approach would also be useful to employ with families where the child did not successfully complete the treatment process. This may shed light on how to work with under-involved families and chronic runaways.

As a follow up to this study, it would be interesting to provide this information to Stratford Homes and do additional focus groups a year later. This could shed some light on the questions of whether families would be more involved if given the opportunity? Are the requests and observations made by the parents reasonable and/or possible to incorporate into a residential treatment program? And, if employed, do these changes increase, decrease, or not effect the length of treatment?

Furthermore, strategies must be developed to deal with parents who want to be involved in the treatment of their
child. What are the best ways to incorporate the strengths and resources of the family and maintain the strengths and effectiveness of Stratford's existing program?

Qualitative research combined with outcome research can provide a clearer picture than either approach used in isolation (Joanning, Newfield, & Quinn, 1987; Moon et al., 1990). Integrating a large outcome study with qualitative methodology could help the field of residential treatment.

**Summary**

The purpose of this research project was to develop an initial ethnographic account of the experience of families who had an adolescent in the residential treatment program at Stratford Homes. The researcher was guided by the assumption that the most effective means to meet the needs of families was to involve them in the decision making process (McBride et al., 1993). The unique aspect of this project was that parents, not residents or professionals, provided feedback regarding the effectiveness of the program.

The results indicated that parents want to be more involved in nearly every aspect of treatment. By being aware of how the family wants to be involved the professionals can modify the treatment program to fit the families' expectations. The findings indicated that families have expectations regarding communication and involvement in
treatment. When these expectations are not met, families become frustrated with the treatment staff. Perhaps residential treatment staffs and other professionals in family services can take these findings to produce a more positive therapeutic experience for the family.
REFERENCES


APPENDIX A

INFORMED CONSENT STATEMENT

Title: A Family Based Description of Residential Treatment at Stratford Homes.

Purpose: The purpose of this study is to develop a descriptive account of the experience of families who had an adolescent complete the residential treatment process at Stratford Homes. The information will be useful in evaluating how families perceive the treatment process and developing methods to involve families in the treatment and decision making process.

Procedure: Information in this study will be gathered by the use of four focus groups. The focus groups will consist of parents who had an adolescent complete the treatment process at Stratford and the group facilitator. The group facilitator is an experienced family therapist who is enrolled in the doctoral program in marital and family therapy at Iowa State University.

The focus group will begin with the participants responding to a questionnaire regarding their involvement with Stratford and the signing of consent forms. The group leader will ask the participants about various aspects of Stratford's treatment process. The participants will be encouraged to respond to the leaders questions and to interact with each around the different issues. Each focus group will last approximately 90 minutes and will be audio taped.

Risk: A risk of participating in this study is the disclosing of uncomfortable feelings regarding involvement in the treatment process.

Benefits: The participants may benefit from hearing about the experiences of other families involved in treatment. Another anticipated benefit is the improvement in the delivery of services to families by Stratford.

Confidentiality: All information will be combined with information from other families in a form that cannot be traced back to you. Neither Stratford or Iowa State will have access to your personal information. Audio tapes and transcriptions will be stored in a locked file cabinet in the Iowa State Marriage and Family Therapy Clinic. Names will not be used on the tape or transcripts.

Any questions you have about the study will be answered before and after the interview. If at any time you wish to withdraw from the study you may with no repercussions from the interviewer, Stratford, or Iowa State University.

____________________________  ______________________________
Signature                                      Date
APPENDIX B
PERMISSION TO AUDIO TAPE

Stratford utilizes various methods of professional supervision and training, such as live viewing, video taping, and audio taping. Staff may be using one-way mirrors and/or VCR equipment both in your home or at our offices. An important part of our services is providing children and families with meaningful feedback and assistance. Taping and live viewing can be very useful in this regard. Secondly, staff also need feedback and supervision regarding their work with clients. The tapes will only be used for these professional purposes. You can withdraw your permission for live viewing and/or taping at any time.

I/we, ______________________, authorize Stratford to tape sessions with my child, ______________________,
and/or family, ______________________, for professional purposes.

_____________________________  ______________________
Parent/Guardian                  Date

_____________________________  ______________________
Witness                        Date
APPENDIX C
PARENT QUESTIONNAIRE

Family ID __________

Based upon your experiences with Stratford's treatment process, please answer the following question by circling a number from 1 to 6 according to the following scale:

<table>
<thead>
<tr>
<th>NOT AT ALL</th>
<th>SOMEWHAT</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

1. Program staff are sensitive to my family's concerns about privacy. 1 2 3 4 5 6

2. Family members and anyone else that I want to be involved in treatment are included by the staff. 1 2 3 4 5 6

3. The staff took my comments and concerns seriously. 1 2 3 4 5 6

4. The staff was non judgmental and respected what was important to my family. 1 2 3 4 5 6

5. The staff used language that was understandable to me. 1 2 3 4 5 6

6. The staff was aware of our family's strengths. 1 2 3 4 5 6

7. My adolescent's strengths were considered in developing a treatment plan. 1 2 3 4 5 6

8. Most of our family's major concerns were addressed in treatment. 1 2 3 4 5 6

9. The staff was sensitive to the family's schedule when scheduling meetings. 1 2 3 4 5 6

10. The staff was honest with information and provided it an open and supportive manner. 1 2 3 4 5 6

11. The staff communicated with me in a respectful manner. 1 2 3 4 5 6

12. Our family had some influence in the decision making process regarding my child's program. 1 2 3 4 5 6
APPENDIX D
FAMILY INFORMATION

Focus Group #_______
Family ID _________

Family Questionnaire

The following questions will let us describe the participants in this study.

1. Mother's age _____ Father's age _____

2. What is your marital status? Check one:
   ____ single
   ____ married or living with partner
   ____ divorced or separated
   ____ widowed

3. What is the highest level of school that you have completed? check one:
   Mother
   ____ partial high school
   ____ high school diploma or GED
   ____ some college or vocational training
   ____ college graduate
   ____ graduate professional training
   Father
   ____ partial high school
   ____ high school diploma or GED
   ____ some college or vocational training
   ____ college graduate
   ____ graduate professional training

4. Mother's occupation_________________________
   Father's occupation_________________________

5. Please give us a general estimate of your family's total income. Check one:
   ____$5,000-10,000
   ____$11,000-15,000
   ____$16,000-20,000
   ____$21,000-30,000
   ____$31,000-40,000
   ____$41,000-50,000
   ____$51,000-74,000
   ____Above $75,000

6. Would you describe yourself as:
   ____ Black (Afro-American)
   ____ Native American
   ____ Hispanic
   ____ White/Caucasian
   ____ Asian
   ____ Other
7. Would you be willing to discuss the focus groups findings with the researcher over the telephone? _____ yes _____ no. It would take 15 to 20 minutes of your time.
APPENDIX E

CLUSTERING OF DATA

This appendix includes an organization of the comments made by parents. The first number represents the focus group in which the comment occurred. The second number is the page number for the focus group transcript.

The parents want Stratford to keep the focus on the child rather than on them
1-4 social worker sees their problem in the child
1-4 parents become the issue instead of the child
1-33 parents felt blamed
3-41 not a problem family rather a family with a problem

Helpful for Stratford to see the family in the home
4-38 like to have someone from Stratford meet the family at their to home get a feel for who they are
4-39 set home visit rules at home so child makes the connection

Parents want to know how Stratford disciplines children so they can follow their example
2-12 want to hear how Stratford deals with problems so parents can try that approach
3-37 want to know of day to day things to help with the transition home
3-39 if something is working at Stratford let parents know so they can try it during a home visit
If family reunification is the goal then let home visits and goals reflect it

1-1 involve the parents in the setting of goals
2-15 want child home more
2-15 want them to stay involved in the family
3-14 if at Stratford for family problems make them work on them
4-1 staff said the goal is family reunification but they keep pulling home visits
4-1 say goal is family reunification but the staff denies contact
4-1 Stratford said they are not use to working with involved families, need to learn
4-8 pulling home visit because of peer's behavior punishes the child and the family
4-21 the more the parent pushed the worse things got, "is the goal to re-unite the family or keep the beds full"

Family therapy
1-7,8,9 family therapist was a liaison between the family and Stratford
2-4 liked having the family therapist joke and get to know them
2-6 felt like family therapy was pushing the wrong angle
2-17 have parents and Stratford staff decide if the home visit will happen
2-20 felt comfortable talking about failures in family therapy but uncomfortable telling social worker and/or residential counselor

2-21 Family therapy's effectiveness depended on the therapist

3-14 if parents not in family therapy then no home visit

3-14 involve everyone, otherwise "child is picking and choosing what things he wants to work on and which things he doesn't"

3-14 if at Stratford to work on family problems make them work on them

3-20 family therapy brought the family dynamics into the cottage, it provided a link

3-23 the family therapist made the child meet with both sets of parents

3-24 family therapist was considerate in setting family therapy time

3-24 family therapist contacted the family to start the process

3-25 helpful that the family therapist kept pressure on our girl to meet with all parents

- did not allow child to manipulate the situation

- family therapist was aware of the process between the child and mom

3-28 sometime the family therapist needs to "dictate" who and what is talked about "this is what is best for the child"
329 like to talk to the family therapist without the child present
-get to know them
-hear their concerns
4-8 family therapist helped them learn how the cottages worked
4-13 before letting the child back home, need to discuss the problem between the parents and child
4-14 as long as child obeyed-Stratford did not push him to deal with issues the parents wanted dealt with
4-24 want the family therapist to be more focused on the task
4-25 if the family therapist does not stay in contact with the family he can get caught up in the child's games
4-28 want more individual therapy for the child
4-29 meet regularly with individual child then meet with the family
4-31, 32 used family therapy as a way to deal with the cottage staff
-did not have to worry about pay backs from the therapist
-family therapist could explain the residential counselor's motives
-someone to vent to
4-33 family therapy should spend more time getting the child ready to return home
4-40 use the home visit forms to see the current problems
4-41 have family therapy six months after discharge
4-43 involve parent in cottage group
-see that resident treats others as bad as he treats her
-mom validated by his peers
-not seen as so bad
-mom could talk differently to resident in the group

Working with Step families
2-6 Stratford was effective in working with divorced families
2-6 hard to get all the participates into 1 session
2-7 want son to improve but unwilling to meet with ex wife
2-8 want separate sessions for each set of parents
2-8 have separate staffings
2-26 issues not discussed between parents, need a forum for that
2-30 invite both sides to pre-visit
3-7 parents not accepted until other mom proved her badness
"once we got through that initial obstacle we were accepted by Stratford"
3-8 get to know both sets of parents before making up your mind about who is right/wrong
3-8 parents received different information, or not as much information as other parents
3-8 Stratford acted like one set of parents were the problem and the other set were the solution
3-9 at pre-visit the other parent said bad stuff about us, be open minded about both sides
3-10 felt like Stratford made a choice on which parents to work with
3-11 Stratford accepted the child's version of the parents' problems and divorce
3-12 stop child from triangulation with parents
  - no visits for first 6 months
  - no influence from parents
  - child focus on self and treatment
3-13 child decided not to meet with one set of parents and Stratford allowed it
3-13 let parents decide who is involved in family therapy not the child
3-14 involve everyone, otherwise "child is picking and choosing what things he wants to work on and which things he doesn't"
3-14 reason the child is at Stratford is to work on family problems so make them work on them
3-15 child pits family members against each other
3-22 other parent told of staffing and consulted about time
3-23 family therapist made the child meet with both sets of parents
3-26 need a forum where one set of parents can discuss the other set
4-23 Stratford needs to be willing to be the bad guy in step family disputes rather than the child or the parents
Advice to professionals

4-14 take more 1 on 1 time with the residents
4-15 have advocate talk with child daily, build trusting relationship, help set goals and evaluate resident progress

Do not let the child use a 'label' as an excuse for behavior

1-24 labels generalize and focus on the past
1-31 don't generalize, treat them like individuals
1-37 Stratford can plant ideas in child's head i.e. alcoholic, abused
3-35 don't let abuse be an excuse for inappropriate behavior
"use those things as a crutch to act the way they act"
4-42 know the child individually, be aware of their personal traits, you don't have to change everything

Listen to their description of the child

2-3&4 child no longer displaying symptom social worker acted like it had "Magically disappeared" mom felt invalidated
2-25 child had them conned-social worker, won't listen to parent
2-25 Stratford had an accurate picture
2-30 not asked for input when child was placed
2-32 not involved in the child's goals
2-40 professionals should ask for parents input
3-41 "remember, the parents know the child better than you do"
4-13 even the psychologist told Stratford the child playing staff against staff. Mom tried to tell them the same thing.
Do/Did the professionals have a good picture of your child?
1-5 spend more 1 on 1 time with the residents
2-3&4 child no longer displaying symptom social worker acted like it had "Magically disappeared" mom felt invalidated
4-13 even the psychologist told Stratford the child playing staff against staff. Mom tried to tell them the same thing.
4-14 as long as child obeyed the rules-Stratford did not push him to deal with issues the parents wanted dealt with

Want to know of "important" issues
1-36 ask questions before punishing
2-10 inform parents about child's school problems
2-11 want to be informed of major issues, not day to day
3-37 want to hear of major things i.e. academics health
3-37 inform of small things so parents can learn from Stratford, help in transition home

Staffings
1-19 involve all that work with the resident
1-19 share good and bad
1-20 no need to focus on parents
2-06 not invited to the first staffing
2-08 have separate staffings for split families
2-26 involve all who work with the child, only way to get whole picture
2-28 keep to one hour
2-28 appreciate residential counselor taking time to talk at staffing
2-29 hear strengths and weaknesses
2-29 talk to parents before the meeting and make it a therapeutic staffing
2-34 staffings designed for the professionals workers
2-34 information flows from Stratford to parents
2-34 not comfortable asking questions
2-35 involve all who work with the resident
3-5 not notified or consulted about home visit or staffings
3-20 viewed it as an informal exchange of information
3-21 comfortable asking questions
3-21 held during parent work hours, not asked for input
3-21 informed by letter, called by referring worker (prefer calls)
3-22 other set of parents told but not them
3-22 not asked about time
3-39 used a special staffing to deal with a special problem
3-39 place to get the day to day information
4-16 did not get a copy of the staffing
4-16 prefer verbal to written feedback
4-17 held infrequently, parent had to push to get it scheduled
4-17 if parents were involved in setting the time it would be easier to attend
4-17 like to have staffings monthly
4-18 don't let child fill out forms at staffing, he was just writing what others wanted to hear
4-18 need agenda and to be more organized
4-18 want an honest evaluation of where child is and what they need to do to get out

**Home visits**
1-21 want more time between family and resident after 30 days
1-26 use home rules to get the child ready for home
1-27 want feedback from home visit forms
1-28 prefer conversation on phone over forms
1-29 give children more home visits
2-15 want residents home more
2-15 want the child to stay involved in the family
2-16 if split family allow resident to go both places each month
2-17 like to be consulted before pulling a home visit
2-17 like to be told of resident's behavior in cottage so they can decide if they want him for home visit
2-17 have family therapy before visit to determine whether to have home visit
2-17 parent, not Stratford, decide if there will be a home visit
2-18 would life Stratford to call and tell them what is going on, do you think he deserves a home visit?
2-18 parent have right to turn home visit into a day visit
2-19 parents not comfortable in answering questions on form
2-19 instead of yes no, some I don't know
2-20 parents uncomfortable reporting failures to cottage
   - be held against child
   - should use as a teaching tool - actions have consequences
2-36 have home visit forms designed for each child's need
2-37 read home visit sheet and then call to give feedback
3-5 not notified or consulted about home visit or staffings
3-14 if parents not in family therapy, no home visit
4-02 why pull home visit because of other resident behavior
4-05 if goal is family reunification why pull home visit
4-06 even when Stratford messed up paper work the child lost
   his home visit
4-08 the behavior of peers should not impact our home visit
4-11 mom put information on home visit sheet but heard no
   feedback
4-40 review home visit papers at family therapy to beware of
   the current problems

**Involve parents to help motivate**
1-16 want to be involved with phase packets
1-19 send packets to parents
   - keep parents informed
   - parents can help push resident
1-36 ask questions before punishing
2-32 want more information on packets—can push and work towards goals on home visits
3-5 not notified or consulted about home visit or staffings
4-02 got packets, want more
4-19 would like clear picture of levels and phases

**Parents want contact with other parents**
1-17 would like a parent support group
1-18 have a night when parents can visit child in the cottage
2-13 more contact with other parents without the resident
2-14 group to be supportive not critical
2-14 like to have parenting class
2-18 if parents talk will hear of inconsistencies between cottage
2-37 family night might be hard on some of the children
2-38 have potluck for parents
2-38 cottage wide, not campus wide
3-32 like parent support group or family activity day
   - feel heard, new ideas, validated no a bad parent
4-37 help to see mine is not the only child like this
4-37 30 minutes just parents, 30 with with resident

**Parents failure Stratford there to fix it**
2-20 parents uncomfortable reporting failures to cottage
   - be held against child
   - should use as a teaching tool—actions have consequences
2-23 don't feel like a customer, more like Stratford is doing them a favor "doing your job because you failed"
3-08 Stratford acted like one set of parents were the problem other parents were the solution
3-38 "say we've got him instead of you and you are on the sidelines"
3-38 "may not have custody, but I am still his parent"
4-08 told "he is no longer yours, he belongs to the state", just accepted they were in charge
Social worker and residential counselor should spend time getting to know the parents/families
1-6 have social worker visit home
2-21 some residential counselor's friendly some not, prefer friendly
2-22 feel like outsiders when the residential counselors were unfriendly
2-22 when residential counselors and parents are not getting along the child uses it to split parents and staff
2-23 residential counselors need to be there for the parents
2-23 residential counselor gave unasked for advice- parent felt it was inappropriate
3-04 if you want the social worker to have information must volunteer it because you won't get asked
3-40 remember each family is different-don't put families into categories
Do not like having the residents' peers having input in their child's treatment
1-34,35 want less peers telling on peers—peers lie, get jealous
4-02 why pull home visit cause of other resident's behavior
4-05 not right to punish a child for another's behavior, builds resentment in the cottage
4-08 peer behavior should impact group activities not individual activities like home visit
4-15 don't like the idea of peer counseling

Stratford's accessibility
1-16 moved nearer Stratford and it increased communication
3-16, 17 parent who makes the most noise gets heard
3-16, 17 "parent who gets Stratford's ears first, that's the key"
3-37 want to hear of major things i.e. academics health
3-37 inform of small things so parents can learn from Stratford, help in transition to home
4-20 if asked the staff questions they would answer, did not volunteer information or start contact

Goal setting
1-26 had to push to have any say in resident goals
2-32 not involved in setting or helping resident achieve goals
3-3 no input into the case permanency plan, had meeting with Stratford officials "got a grip on what she needed"
3-26 family, not child say who will be in family therapy
3-28 sometime the therapist needs to "dictate" who and what they talk about "this is what is best for the child"
4-41 hard to set rules for return while child still in Stratford, "too unreal"

After care
3-5 find out how things are going
4-35 family therapist could serve as an arbitrator while child builds trust with the parents
4-41 follow-up at 6 months

Communication Flow
1-16 moved nearer Stratford and it increased communication
1-28 prefer conversation on phone over forms
1-32 get to know the parents
1-32 "complete circle" everyone working together-resident, pros, parents
1-33 resident say bad things about parents and the residential counselor just believes them
1-33 resident played Stratford staff against parents and vice versa-stop by making communication "complete circle"
1-36 ask questions before punishing
1-37 don't share resident's past with other residents
2-02 don't talk down to the parents
2-05 Stratford did not act as if they had all the answers
2-11 parent calls Stratford Stratford does not call them
2-22 when residential counselors and parents are not getting along the child uses it to split parents and residential counselors
2-23 residential counselor gave unasked for advice- parent felt it was inappropriate
2-37 read home visit sheet and then call to give the parents feedback
3-03 mom had to push to get child into summer school
3-04 Stratford does not call them, want information must call them
3-05 to get information parent has to be pushy
3-06 have to ask Stratford for everything
3-07 Stratford listened to referring worker which created problems
3-12 child used conflict between parent and residential counselor to get way
3-16, 17 parent who makes the most noise gets heard
3-16, 17 "parent who gets Stratford's ears first, that' the key"
3-21 like phone calls
4-02 felt well informed
4-10 can understand residential counselor's behavior towards child when understood the goals of the residential counselor
4-11 wants feedback from home visit sheet
4-12 phone call or something to say I talked to the child
4-20 gave information to cottage, but no feedback
4-30 child used journal to make parent look bad, Stratford
never asked parent for input/clarification
4-16 prefer verbal to written feedback

Advice to parents
1-30 treatment will be tough, but it will help the child, get
involved, ask questions, know what is going on, know what is
expected of your child
1-31 don’t assume the professionals know more
2-33 know goals, support child, be pushy, learn terms speak
out, be honest, know referring worker

Advice to professionals
1-31 don’t generalize, view resident as individuals
2-34 be aware of how hard it is to leave resident at Stratford
2-35 listen to parents, be honest and open, meet parents
without child, make sure parents really understand
3-40 put self in parents position leaving child at Stratford
3-41 keep an open mind and be objective
3-41 “remember the parents know the child better than you do,
access that knowledge”
3-41 tough leaving a child
3-41 remember that parents want to be involved
3-42 tough transition for the parents
4-42 don’t get to close to the resident because the children
will use them
4-42 keep a line between personal and professional

Relationship with social worker and resident

2-24 liked being treated like a friend

2-24 like time to talk to residential counselor about resident progress

2-24 felt like residential counselor was in control not them

2-39 wanted chance to discuss progress with residential counselor

2-39 parents would like assurances that the resident is safe and will not be harmed

3-5 felt like outsiders

3-25 not the position, person in the position

3-34 felt supported by residential counselor

4-3 had personal relationship and felt informed

4-5 got along when I shut-up and played the game

4-6 everything went better when quit bucking the system

4-8 quit complaining and play the game

4-21 the more I pushed the worse it got

4-22 liked working with social worker not residential counselor

4-43 helpful for child to have the same residential counselor

Decision making

2-24 felt like the residential counselor was in control not them
3-5 was told "you are turning your child over to them. You have no say so anymore in anything"
3-5 not notified or consulted about home visit or staffings
3-13 child decided to not meet with one set of parents and Stratford allowed it
3-13 let parents decide who is involved in family therapy not the child
3-18 family conflict was the ticket into Stratford, but child was allowed keep those issues from being dealt with, still a problem
3-37 want to hear of major things i.e. academics health
3-37 inform of small things so parents can learn from Stratford, help in transition to home
3-38 "say we've got him instead of you and you are on the sidelines"
4-08 told "he is no longer yours, he belongs to the state", just accepted they were in charge
4-10 pull home visit if the resident's behavior is bad
4-10 want to be more involved
4-11 just told home visit pulled not consulted
4-39 like to help set rules for home visit
4-41 hard to set rules for return while child still in Stratford, "too unreal"

pre-visit

2-30 ask both sets of parents
2-30 not asked for input when child was placed
2-31 helpful to see the facility, present concerns, felt involved
2-31 learn terms i.e. shut down
2-39 parents would like assurances that the resident is safe and will not be harmed
3-9 at pre-visit one set of parents set things up against the other set of parents
4-1 not helpful—so many papers to sign felt overwhelmed
4-1 warn parents to expect negative letters
4-1 if more aware of process it would reduce panic/anxiety
4-1 weren't sure what to expect i.e. length of stay
4-1 unsure of rules and their purposes
4-9 got off on wrong foot with residential counselor about resident's haircut