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How home-based clinicians assess and assist parent(s) who experience changes in family dynamics post discharge of their pre-latency/latency age child's first psychiatric hospitalization

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CHAPTER I

INTRODUCTION

It can be assumed that the psychiatric hospitalization of a child is highly traumatic not only for the child, but for the family as well. A great deal of research has been published (Dicker, Morrissey, Abikoff, Alvir, Weissman, Grover, Koplewicz, 1996; Flouri and Buchanan, 2002; Lukens, Thorning, and Lohrer, 2004; Marsh, 1998; Marsh and Johnson, 1997) that focus on 1) changes in families that occur after the psychiatric diagnosis of a child and 2) hospitalization as a treatment option for children. What is missing is the connection between the discharge from the psychiatric hospital and how clinicians deal with the resulting changes in family dynamics. Marsh and Johnson (1997) found that “most families do survive the catastrophic event of mental illness. None does so without experiencing family disruption and stress...” (p. 231). Parents frequently face a difficult decision whether or not to hospitalize their child and they often make this decision with or without the help of a clinician. When the child is discharged, the family may experience changes in dynamics that destabilize the home even when engaged with a clinician. The objective of this study was to gain a deeper understanding of what those changes in family dynamics were through the perceptions of home-based therapists who have been working with the family pre, during, and post hospitalization. Home-based clinicians have the training to recognize, assess, and assist families who experience changes in family dynamics. Therefore, home-based therapists comprised the sample for

the current study and they were asked to share their experiences and interventions used after having worked with these families.

The objective of this study was to gather information on how home-based clinicians assess and assist parent(s) who experienced changes in family dynamics post discharge of their pre-latency/latency age child's psychiatric hospitalization. In order to better understand the perspectives of home-based therapists, interviews were conducted with 12 home-based clinicians who were licensed in their discipline and had several years experience in the field working with families where a child has been hospitalized. Also the therapist needed to be present in the home pre, during, and post hospitalization. The interview process, 45 minutes to an hour in length, allowed clinicians to share their observations and describe how they have assisted families to readjust and stabilize after discharge.

There is limited research that has examined the effects of psychiatric hospitalization on family dynamics and family systems. Currently there are some published studies and articles (Lukens, Thorning, Lohrer, 2004; Marsh, 1998; Marsh and Johnson, 1997) that make clear that changes in family dynamics do occur. Yet the findings of these studies do not clearly describe those changes in family dynamics and do not specify how and when they occur after hospitalization. Also there is limited research on home-based therapy and the clinicians who take part in this unique intervention.

This study was designed to give future clinicians a more in-depth understanding of what changes they should expect when working with families who have had a child that has been psychiatrically hospitalized. The findings of this study may provide other

home-based clinicians with information on effective interventions that allow for the child's transition back in the home to be positive.

CHAPTER II

LITERATURE REVIEW

The research question for this study was: How do home-based clinicians assess and assist parents who experiences changes in family dynamics post discharge of their pre-latency/latency age child's first psychiatric hospitalization? There were gaps in the previous research in that the topics of home-based therapy, psychiatric hospitalization of children, and changes in family dynamics post discharge were not specifically addressed. The few studies (Costello, Dulcan, and Kalas, 1991; Cottrell, 1994; Dicker, Morrissey, Abikoff, Alvir, Weissman, Grover, Koplewicz, 1996; Flouri and Buchanan, 2002; Hillard, Slomowitz, and Deddens, 1988; Lukens, Thorning, and Lohrer, 2004; Marsden, Kalterm Plunkett, and Grossman, 1977; Marsh and Johnson, 1997) that did examine how children become hospitalized, how families react to the diagnosis of a child, and ways in which home-based therapy is a benefit and potential disadvantage to a family will be reviewed.

This chapter consists of several sections drawn from the key concepts contained in the research question for this study. The first section describes the psychiatric hospitalization of children and is divided into sub-sections including: criteria for hospitalization, types of hospitalization, duration of treatment, criteria for discharge, post discharge transition, and cultural and ethnic factors. It is important to understand how children become hospitalized and the protocols for treatment and discharge. The second

section presents the previous research that addresses psychological diagnosis of children, effects of diagnosis on child/parent/sibling, treatment, and cultural and ethnic factors. This section also addresses the effects a mental illness diagnosis of a child can have on a family. The third section examines those studies and articles that focus on the development of pre-latency/latency age children in terms of cognitive development, attachment, and social development. The fourth section reviews the literature on home-based family therapy with a focus on clinician qualifications, referral process, benefits, and disadvantages. The fifth and final section presents the literature on family therapy with a focus on family dynamics and family theory. The studies in this section describe what theories and theorists say about family therapy and family dynamics.

Psychiatric Hospitalization of Children

Psychiatric hospitalization is a treatment intervention that can be used for children who have behavioral issues or who are diagnosed with a mental illness. According to Costello, Dulcan, and Kalas (1991) “Each year in the U.S. more than 130,000 children are hospitalized for psychiatric reasons” (p.823). Yet, there are consequences that can arise as a result of this intervention. A professional or parent would only consider hospitalization if all other interventions have been found to be ineffective. The purpose of reviewing the following literature is to define and describe psychiatric hospitalization with subsequent headings including: criteria for hospitalization, types of hospitalization, duration, discharge, post discharge transition, and cultural and ethnic factors.

Criteria for Hospitalization

The psychiatric hospitalization of a child is a choice that takes a great deal of consideration and one that should not be made lightly. The decision to hospitalize a child frequently results in a disruption of family dynamics. Costello et al (1991) stated, “A child’s admission to a psychiatric hospital has a major impact on the child and the child’s family” (p 823). Given that the purpose of this study is to gain a deeper understanding of the disruption of family dynamics as seen through the eyes of a home-based therapist, it is essential to describe the criteria for the psychiatric hospitalization of a child.

The American Academy of Child and Adolescent Psychiatry (AACAP) (1989), developed guidelines for the hospitalization of a child. A major criterion is the presence of a psychiatric disorder as defined by the Diagnostic Statistical Manual III-R. This psychiatric disorder must also be so severe that it causes significant impairment in daily functioning in at least two areas of the child’s life. Daily functioning for a child according to the AACAP, includes school performance, social interactions, or family relationship. The AACAP also requires that the hospitalization of a child must be only considered as a last resort when all other available less restrictive treatment have been considered. The decision to hospitalize, according to the AACAP, can only be made by a qualified child psychiatrist or a general psychiatrist with documented specialized training (p.1).

Once the child is hospitalized and progresses through the system there are more guidelines the American Academy of Child and Adolescent Psychiatry proposes. Understanding the criteria for hospitalization allows other researchers the opportunity to study whether those admitting the child do indeed follow these guidelines and the criteria by which children are admitted.

Dicker, Morrissey, Abikoff, Alvir, Weissman, Grover, Koplewicz (1996) conducted a study that examined the psychiatric hospitalization criteria for adolescents, with a specific focus on suicide. Dicker et al (1996) structured their study around Hillard, Slomowitz, and Deddens' (1988) conclusion, "The presence of suicidal tendencies was the strongest predictor of adolescent admissions in a sample of 100 adolescents evaluated in a psychiatric emergency service" (p. 1418). Hillard et al (1988) found that suicidal ideation, physical abuse, schizophrenia, and age (younger children are hospitalized more frequently) were major factors in the decision to hospitalize children (p. 1418). Dicker et al (1996) created a questionnaire that contained 63 vignettes describing adolescent suicide attempts. Six variables of lethality were included in these vignettes including: gender, presence of depression, conduct disorder, substance abuse, history, and previous attempts. Dicker et al found that, "Results show that hospitalization preference was significantly predicted by all risk factors except for gender, with the presence of depression emerging as the most important predictor of hospitalization" (p. 769). Dicker et al, despite looking at adolescents and limiting their criteria for hospitalization to suicide and suicidal factors, made clear how some adolescents become hospitalized. Although this study did not provide specific criteria for hospitalization, Dicker et al did describe the mental status of some adolescents before they are hospitalized, such as suicidal or depressed. This study offers one scenario out of the hundreds that families could experience before they make the decision to hospitalize. It is the purpose of the current study to understand how home-based therapist assess and assist families before, during and after the hospitalization with a focus on the possible changes in family dynamics that could occur.

In an attempt to better understand the reasons for hospitalization of children, Costello, Dulcan, Kalas (1991) created a 12-item checklist of criteria that they believed would correctly predict whether the child should be hospitalized. The checklist of criteria for hospitalization included: questions around suicide, suicidal ideations, aggression towards others, threatening behavior, antisocial behavior, reality testing, the failure of other treatment (including outpatient), physical/neurological/psychotic condition, family history, emotional contact, and 24-hour observation (p. 826). Out of a cohort of 389 children, ages 2-12, who were evaluated for either inpatient or outpatient treatment over the course of one year, 89 were subsequently hospitalized. Costello et al (1991) concluded that, “In 95 percent of the cases, the checklist was able to correctly predict whether the patient was hospitalized” (p. 823). The researchers further broke down their findings and reported that gender, age, or diagnoses were unrelated to admission. This study investigated the hospitalization of children ages 2-12, which encompasses the ages (6-12) of children treated by the home-based clinicians in the sample for the current study. Costello et al also accurately detailed some of the reasons for hospitalization that could be described by the interviewed home-based clinicians.

Types of Hospitalization

The current literature describes two types of psychiatric hospitalizations, public and private. Private hospitalization, a growing trend (Barber, Allen, Coyne, 1992), tends to be overwhelmingly expensive for families and many practitioners are attempting to avoid hospitalization due to the increasing costs. Despite this push for hospital avoidance

by practitioners there is mounting pressure from the private health care corporations due to reimbursement rates. According to Mason and Gibbs (1992):

The most prominent concern is that private health care corporations are aggressively marketing inpatient services for juveniles because of the increasing availability of reimbursement by third party health care providers that favor inpatient over outpatient treatment (p.447).

This push by the private health care corporations is directed towards private hospitalization rather than public. Mason and Gibbs, who analyzed demographic and institutional patterns among adolescents, found that, “Patients were likely to stay significantly longer on average in private psychiatric hospitals than in state and county hospitals or general hospitals” (p.450). Further analysis by Mason and Gibbs (1992) showed that out of the adolescent records reviewed, seventy-one percent were privately insured and were hospitalized in private institution (p.453). Marketing by public hospitals is not as lucrative for health care corporations. Families who can afford to hospitalize their children do so in private, well-funded hospitals. In addition to the monetary difference between public and private hospitals, Mason and Gibbs found racial disparities between the two institutions. Mason and Gibbs reported, “Minority groups were far more likely to be treated in state and county facilities and far less likely to be treated in private psychiatric hospitals than were whites” (p.454). Thus, minority groups are highly underrepresented among the privately insured.

Although Mason and Gibbs looked specifically at adolescents, age 14-17, and pre-latency/latency age is the focus of the current study they, along with Barber et al (1992), thoroughly explained the difference between private and public hospitals. The differences presented in both studies are relevant to the current study. Differences in

length of stay as well as access to monetary funds, which could impact treatment, are both factors that could impact the family dynamics once the child returns home.

Duration of Treatment

There are differing opinions on the optimal length of stay for children in psychiatric hospitals. These differing opinions center on the diagnosis and symptoms of the child. This is precisely the idea that Barber, Allen, and Coyne (1992) explored. Their study included 29 staff members of a children's clinic. Barber et al (1992) examined the factors that determined the length of stay for children in an inpatient setting. Barber et al asked the participants to write short vignettes describing what they thought would be the diagnosis of a child who would be hospitalized short term, intermediate, or long term given that the length of stay ranged from four weeks to two years. Barber et al wrote:

The concepts used by the clinicians fell into three domains. The patient domain included diagnosis and symptoms, strengths and assets of the patient, and the course and severity of psychopathology. The treatment domain included information on prior treatment, modalities to be used during hospital treatment, and plans for post hospital treatment. The environmental domain included social support, stressors, family resources and liabilities, and traumatic history (p. 460).

The overall findings showed differences among a wide range of diagnoses and symptoms. Short-term stays included diagnoses of adjustment disorder with symptoms of impulsivity and school problems. An intermediate stay was considered when a child presented with affective disorder, substance abuse, and eating disorders with behavioral symptoms that included suicidal behavior. The diagnoses and symptoms thought to be appropriate for a longer term stay included schizophrenia, personality disorder, and conduct disorder with presenting symptoms of psychosis, interpersonal problems, and aggressive/destructive behavior (p. 461). According to Barber et al (1992), the criteria for

length of hospitalization emerged from the diagnosis and presenting symptoms upon intake. It is important to take into account the length of a child's stay within the hospital because the duration could effect the changes in family dynamics when the child is discharged. Also the length of hospitalization could effect the home-based treatment. If the child remains in the hospital for several months, home-based therapy could terminate due to the long hospitalization time.

Criteria for Discharge

In addition to understanding why a child is hospitalized, it is also critical to understand the criteria for discharge. Katz and Woolley (1975) studied the criteria for discharge used in psychiatric hospitals. Twenty-one criteria were identified by the 43 staff surveyed and were rated according to perceived importance. Discharge criteria included twenty three criteria: does not constitute danger to self and others, behavioral improvement since admission, stable living arrangement upon discharge, has access to outpatient treatment, social behavior appropriate, and reduction in deviant behavior, etc. Katz and Woolley noted that, "For the most important criterion, the largest group, 18, selected number 11, 'functions in an acceptable manner and is no longer harmful to himself or others'" (p.35). Following this, participant chose number two "does not constitute a danger to himself or others," number four "assumes responsibility for his behavior," and number five "behavior improvement sufficiently strong to be maintained outside of the hospital" as the most important discharge criteria (p. 35). Katz and Woolley inferred that specific criteria for discharge, similar to that of the intake criteria, were needed. The importance of specific discharge criteria is relevant to the current study

in terms of a child's mental status at the time of discharge. The child's mental status upon discharge impacts the changes in family dynamics and the ways in which home-based therapists perceive those changes. If a child is still a threat to self or others the dynamics between family members could be drastically different from a child who is no longer a threat. Also if a child's behavior is stable a discharge the family's dynamics maybe less impacted compared to a child who is still acting out. Although Katz and Wooley (1975) focused on adult hospitalization and the sample size was quite small, the findings provide needed information in understanding the impact hospital discharge and a child's current mental state can have upon a family.

Post Discharge Transition

Discharge from a psychiatric facility not only of children, but also of all patients, can be a tumultuous time and one where a patient is uncertain of what to expect. The patient's quality of life is in question following the discharge. Many patients ultimately return to the hospital because they are unable to transition back into society due an increase in negative and violent behaviors (Grisso, Davis, Vasselinov, Appelbaum, Monahan, 2000). The following researchers (Grisso, Vasselinov, Applebaum, Monahan, 2000; Nolan, 1997; Prince, 2006) described 1) the ways in which family dynamics could be disrupted and 2) the potential situations home-based clinicians could experience. Examples of situations that could occur after the discharge of a patient are described below.

Jonathan Prince (2006) looked at 259 individuals with schizophrenia and compared their ethnicity and quality of life following a discharge from an inpatient unit.

What Prince (2006) found was that “subjective life quality is higher in Blacks than in Whites with schizophrenia...” (p. 204). Prince added that Blacks self-reported a greater degree of satisfaction with their health, use of spare time, and amount of fun they experienced. Although there were several limitations to this study including age, a sample of adults, and limited information concerning location upon discharge, it can be assumed that discharged patients, child or adult, can have a range of experiences when transitioning back home or to a step down unit. This range of transitional experiences, either positive or negative, can substantially change the family dynamics within the home. One purpose of this study to understand those changes from the perspective of the home-based clinician.

There are those individuals who have a smooth transition back into society after a psychiatric hospitalization. However many discharged patients do find it difficult to adjust and consequently need to be readmitted into the hospital, several times if necessary, until a level of stabilization is reached. Jennifer Nolan (1997) surveyed 356 patients who were discharged from three short-term inpatient psychiatric wards in the state of New York. Nolan tracked their discharge and twelve months later re-surveyed to determine the number of readmissions to the psychiatric facility. Nolan’s results showed, “The rehospitalization days per post discharge month per 100 discharged patients was 37.6% or 134 patients of the discharged cohort had at least one readmission within a year” (p. 81). However, Nolan surveyed only those adults who were eighteen and older and this is a very narrow sample of the potential outcomes of psychiatric hospitalizations. Although Nolan only surveyed adults and the current study hopes to better understand a

child's discharge, readmission to the hospital, of a child or any individual, can be an overwhelming disruption to the family dynamics in or outside of the home.

Grisso, Davis, Vesselinov, Applebaum, Monahan (2000) conducted a study that examined violent thoughts and violent behavior following hospitalization for mental disorders. Grisso et al (2000) surveyed 1,136 patients who were currently hospitalized with a mental illness and followed these patients once discharged. The findings showed that, "Among patients who reported violent thoughts while in the hospital, about one half or more did not report such thoughts during post discharge follow-ups, whereas about 20% and 30% reported thoughts rather consistently across time" (p. 395). Although Grisso et al (2000) surveyed adult individuals, the findings gave a better understanding of the impact of mental illness and the disruption violent thoughts and behaviors can have upon a family system. If an individual, whether an adult or child, returns to the home with violent thoughts and behaviors, the family could experience changes in dynamics to better adjust themselves to the behavior of their family member. It is the purpose of the current study to understand how home-based therapists assess (those changes) and assist (intervention techniques) families after the child transitions back into the home.

Hospital discharge creates a great deal of stress within a family. The uncertainty of the mental state of the child and how to deal with post-discharge behavior are two examples of family stressors. The resulting changes in family dynamics may create significant upheaval in the home. The purpose of the current study is to better understand the extent of the changes in family dynamics, the underlying reasons for those changes, and the possible interventions implemented by home-based clinicians.

Cultural and Ethnic Factors

When examining the hospitalization of children it is important to review the literature on cultural and ethnic differences. This difference can play a role in whether a child is hospitalized. Kilgus, Pumariega, Cuffe (1994) conducted a study that examined racial differences among adolescents who were hospitalized. Lewis et al (1980) as cited in Kilgus et al found that, “Violent African-American youth were more likely to be incarcerated whereas white youth were psychiatrically hospitalized, even though both groups were equally psychiatrically impaired” (p. 67). Kilgus et al reviewed 352 psychiatric inpatient records and found in response to hospitalization “African-Americans were twice as likely to be involuntarily committed at the time of admission” (p. 68). Although this study focused on adolescents and the research was limited to one psychiatric hospital, Kilgus et al exposed the bias found in the mental health field. These biases are relevant to the current study due to the fact that an adolescent or child could be hospitalized or incarcerated based on their race. Either way, family dynamics will change drastically. The current study will focus on hospitalization not incarceration. Since most hospitalized adolescents are white (Kilgus et al, 1994) there may be limited diversity among the families reported on by the home-based therapists therefore altering the results.

Psychological Diagnosis of Children

How a family member reacts to a diagnosis of mental illness in a child can frequently determine how extensive the changes are that occur in the home. When a child is psychiatrically diagnosed, it is not only the parents that have to adjust, but the other

siblings as well. Pauline Boss (1992) wrote, “Perceptions, even more than resources, predict which families manage high stress and which fall into crisis” (p. 113). Boss’ statement relating to families’ perceptions of stress, gives a brief, but clear explanation of how families may react when a diagnosis of mental illness is given. Psychiatric hospitalizations intensify the stress and families can either show resiliency or experience difficulty maintaining homeostasis. The following sub sections describe how children are diagnosed and how the child and individual family members react to a diagnosis of mental illness with a focus on child, parent, and sibling reactions, race and ethnic factors, and treatment of diagnosis.

The Process of Psychiatric Diagnosis

“The current system for diagnosing childhood psychiatric disorders in clinical practice is the DSM-IV that specifies clear rules for evaluating a patient for the presence or absence of a specific disorder” (Lefkowitz, 2006, p.1706). Yet, as Lefkowitz explained, practitioners frequently forgo the Diagnostic Statistical Manual IV and use individual theories about different disorders thus making diagnoses in children as diverse as the diagnoses found in adults. Some shared diagnoses for both adults and children include the affective disorders as noted by Kovacs (1989), “There is now compelling evidence from a diversity of studies that school-aged children and adolescents do experience depression” (p. 209). Barber, Allen, and Coyne (1992) referred to diagnoses of anxiety disorders, personality disorders, eating disorders, substance abuse, schizophrenia, adjustment disorder, and conduct disorder (p. 461). Despite many similarities between adults and children there are a few disorders that are specifically

found in children or diagnosed during childhood. The DSM-IV-TR (2000) lists the following: mental retardation, learning disorders, motor skill disorders, communication disorders, pervasive developmental disorders, attention-deficit and disruptive behavior disorders, tic disorders, and elimination disorders as specific disorders diagnosed or found only in children. (p. 13-14). Although a child can be hospitalized for a number of reasons, not all of the specified childhood disorders found in the DSM-IV would fit the criteria for hospitalization. Yet it is important to recognize these diagnosable conditions because they, along with the disorders that meet the criteria for hospitalization, can impact family dynamics.

Effect of Diagnosis on Child, Parent, and Sibling

When an individual is diagnosed with a mental illness, it can be devastating. Yet some individuals adjust to compensate for this diagnosis and the reverberating impact is minimal on the family. However, in the case of childhood mental illness, not only is the child's world disrupted, but the parents and siblings who live within the home are also thrown into disorder. Marsh and Johnson (1997) wrote:

Indeed, the current system of care is as much family-based as community-based, and families generally serve as the first and last resort for their relatives, often with little professional guidance. In the present era, families fulfill crucial roles as primary caregivers for relatives who reside in the home, as informal case managers who advocate for their relatives with service providers, and as crisis intervention specialists who handle relapses and emergencies (p. 229).

From child, to parent, to sibling, family members within the home are no doubt affected by the psychiatric diagnosis of a child. What follows is an exploration about how the child, their parents, and siblings react to the psychiatric diagnosis.

Child's Reaction: Marsden, Kalterm Plunkett, and Grossman (1977) interviewed 31 fourth and fifth graders to obtain their judgments concerning emotionally disturbed peers. The children in the sample were presented with five vignettes each describing a different child with separate emotional states including, "normal," aggressive, passive-aggressive, school phobic, and borderline psychotic. After the children heard the vignettes they were asked to give their opinion. The findings showed that "the normal central figure was disliked significantly less than the aggressive and the passive-aggressive disorder central figures, and both of these were disliked significantly more than the borderline and the phobic central figure" (p.948). Marsden et al's (1977) study revealed a child's reaction to a mental illness diagnosis. Although Marsden et al did not specifically look at the child who is being diagnosed and their opinion about themselves, which the current study proposes to do, the findings do show that children, similar to parents and siblings, can have a reaction to mental illness.

Parents' Reactions: According to Marsh and Johnson (1997), families experience a wide range of emotions following the psychiatric diagnosis of a family member. Grief, symbolic loss, chronic sorrow, and empathetic pain are reactions families can experience in response to the mental illness of a close relative (p.230). Marsh and Johnson described how parents can have a more specific reaction to the diagnosis, "When a child develops a mental illness, his or her parents generally experience a range of intense losses, both real and symbolic" (p. 232). Marsh and Johnson added that parents are prone to feelings of guilt and responsibility and frequently become primary caregivers for a lifetime. Marsh (1998) wrote, "They [parents] seemed to be trying to find out how we caused it. It was just devastating." (p. 232). Marsh and Johnson's findings showed that parents have a

wide range of reactions to the diagnosis of a child. Given these findings, it can be safe to assume that family dynamics shift in response to that diagnosis. Although Marsh and Johnson left out the responses to psychiatric hospitalization, they clearly described the devastating effects of mental illness upon the parents. Marsh and Johnson (1997) set the stage for how home-based therapists assess and assist families with a similar situation by their clear presentation of responses from families including, grief, symbolic loss, chronic sorrow, and several others.

Contrary to the findings of Marsh and Johnson's study where the parent's reactions to the mental illness were one of concern and sadness, a separate study conducted by Flouri and Buchanan (2002) described parents whose reactions to their child's psychiatric diagnosis and hospitalization was distant and uninvolved. Flouri and Buchanan (2002) surveyed 2,722 adolescents to determine if parental involvement can prevent adolescent suicide attempts. Flouri and Buchanan wrote, "This study showed that adolescents who reported higher parental involvement were less likely to have made suicide attempts...that apart from parental emotional support, parental responsibility, engagement, and accessibility protected against attempted suicide" (p.21). Flouri and Buchanan found that out of the 2,722 participants in the sample, 291 students reported that they had attempted suicide many of that number had been hospitalized as a result. The findings showed that adolescents whose parents were more in tune and had better relationships with their child were less likely to have attempted suicide. Parents who were less engaged, not accessible, and took less responsibility had children who were more prone to depression and suicidal ideation. Flouri and Buchanan surveyed adolescents as opposed to latency aged children who are the focus of the current study. However, the

relationship between parent and child and the association with depression may be generalized to fit most populations. Flouri and Buchanan (2002) made clear that depression is an illness found in children, and parents can have a great effect on how children adjust (or not adjust) to their diagnosis. The current study examines ways in which a therapist could assess and assist parents in helping their child overcome such a devastating obstacle, such as mental illness.

In both studies (Flouri and Buchanan, 2002; Marsh and Johnson, 1997) the researchers present conflicting images of a parents' reaction to their mentally ill child. In many cases parents are motivated to support and assist their child and in other cases parents chose to ignore the warning signs. In either case the effects that childhood mental illness can have upon family dynamics is great. Although these studies clearly described parents' reaction to mental illness, it still leaves the door open for more research in the area of childhood psychiatric hospitalization, home-based family therapy, and changes in family dynamics after hospitalization.

Sibling Reactions: In many cases it is not only the parents who experience profound emotions when their child is psychiatrically diagnosed. Siblings may be just as devastated by the psychiatric diagnosis of their brother or sister. The purpose of a study conducted by Lukens, Thorning, and Lohrer (2004) was to explore the concerns and needs that siblings faced with a brother or sister who is mentally ill. Lukens et al conducted focus groups to gather responses from nineteen adults who had siblings with a diagnosed mental illness. The mental illness diagnoses were as follows: schizophrenia, bipolar disorder, and major depression. Lukens et al found that, "The participants reported that the illness affected their sense of personhood deeply and on a daily basis.

Across the focus groups, all the siblings consistently described a complex of negative emotions, including anger and guilt, mourning and loss, fear, and anticipated (or future) burden” (p. 492). Although the sample in this particular study was small and included only the retrospective reports from older adults, the findings gave a clear representation of the emotional reactions many siblings face with the diagnosis of their brother or sister.

Marsh and Johnson (1997) also made reference to how siblings are impacted by a mental illness diagnosis of a brother or sister. Marsh and Johnson wrote, “Siblings may experience the dual losses of their brother and sister and of their parents, whose energy may be consumed by the mental illness” (p. 232). Marsh and Johnson also noted how this loss of not only their sibling, but of the parents as well can undermine a child’s acquisition of basic trust. In later years, this loss can impact peer development, and the establishment of a secure sense of identity. Given these effects, many siblings experience anger and a sense of lost childhood (p. 232). Lukens et al, (2004) wrote, “Mourning was associated particularly with the loss of innocence and the fantasy of a more ordinary childhood untainted by mental illness” (p. 494). The emotions that are evoked within a sibling after the diagnoses of mental illness are similar to that of a parent. This occurrence of concurrent emotions in the parents and siblings is bound to create change because of different roles family members will be taking on and the heightened emotions in and between family members. Finding out more about what the changes are and how home-based clinicians assess and assist parents is the basis of the proposed study. The previous research (Lukens et al, 2004; Marsh and Johnson, 1997) has shown that both parents and siblings experience intense emotions consequent to the psychiatric diagnosis of a child or sibling. Given the array of feelings that can arise from the

diagnosis including, sadness, anger and frustration, changes are likely to occur in the roles and interactions of all family members. This study again hopes to understand what those changes are and how clinicians help families stabilize.

Treatment of the Child and the Family

There are numerous clinical interventions that can be utilized when working with children who have been diagnosed with a mental illness. Outpatient therapy (in a clinic), medication, residential treatment, hospitalization, and home-based therapy are all ways in which the treatment of children is provided (American Academy of Child and Adolescent Psychiatry, 1989; Brown and Sammons, 2002; Cottrell, 1994; National Youth Network, 2007). Each treatment strategy has its own unique style and is used with a wide range of diagnoses. Understanding the different treatment options available to children and their parents allows the present study to be more clearly defined and home-based therapy to be seen for what it is and is not.

Outpatient Therapy

Outpatient therapy that is conducted within a clinic provides a wide range of services to diverse populations. According to the National Youth Network (2007):

Outpatient therapy provides therapeutic intervention to individuals in need of mental health resources, but who do not require hospitalization or residential care. Outpatient therapy is beneficial in providing initial assessment regarding the need for psychiatric counseling, as well as offering follow up support to individuals... Outpatient programs are tailored to the needs of the individual and may include individual and/or group counseling, family therapy ... it provides ongoing, though brief therapeutic interventions that support and guide individuals as they work to overcome the challenges inherent in their day-to-day lives (p. 1).

Although home-based therapy most resembles and incorporates some of what is outlined by the National Youth Network regarding outpatient therapy, there are also several differences. Outpatient therapy incorporates aspects of home-based therapy; however the family visits the clinic and the information that could be obtained while visiting the home is understandably absent (Cottrell, 1994). Also outpatient clinics do not interact with a portion of the population due to transportation issues, therefore home-based therapists have a greater variety of clients. As Cottrell (1994) stated, “There are some families who want help but who find it genuinely difficult to get to the clinic” (p. 191). These examples give a better understanding of the ways in which home-based therapy and outpatient clinic therapy overlap and are different.

Psychotropic Medication

Medication to treat many psychiatric disorders of a child has been on the rise in recent years due the increased prevalence of psychotropic medications and research surrounding childhood diseases. Brown and Sammons (2002) suggested, “The body of knowledge in neural physiology parallels new developments in psychopharmacology and has led to the introduction of a large number of pharmacotherapies that are specific to cognitive processes, learning, and psychopathology” (p. 135-136). Brown and Sammons added, “Those disorders that have accounted for the majority of psychopharmacology prevalence studies include attention deficit hyperactivity disorder (ADHD), mental retardation and developmental disabilities, seizure disorders, autism spectrum disorders, mood disorders, enuresis, and Tourette’s syndrome” (p. 137). Many children are prescribed medication in the hospital setting, including stimulants, antidepressants, mood stabilizers, and anti-psychotics to stabilize behavior and return home with a prescription

(Brown and Sammons, 2002). Although children can be stabilized in the hospital, disruption may occur in the home upon discharge. It is the purpose of this study to understand how home-based therapists assess and assist parents with a child who is discharged from the hospital and experience changes in family dynamics.

Residential Treatment

Residential facilities are an alternative treatment used for children, adolescent, and adults. According to the National Youth Network (2007):

Residential treatment placements provide specialized assistance to individuals requiring professional clinical support to facilitate emotional and behavioral change and growth. Offered in a wide variety of milieus, residential treatment programs serve to remove adolescents from the home setting, and place them in a structured, supervised, therapeutic environment (p. 1).

Residential facilities work with a variety of identified issues including: substance abuse, eating disorders, and behavioral problems. Although residential facilities and home-based therapists may focus on the same issues, the differences are apparent in the location where therapy is conducted.

Racial and Ethnic Factors

Although one would surmise that race and ethnicity would not affect the diagnosis of children, this is often the case. It is essential to understand how race and ethnicity play a role in the diagnosis of children, for a difference in diagnoses could mean different changes in family dynamics. Kilgus, Pumariega, and Cuffe (1994) reviewed hospital records and nurse reports for 352 adolescents in a psychiatric setting over the course of one year. What Kilgus et al. (1994) were looking for were differences in diagnosis between African American and White adolescents. Kilgus et al wrote, “African –

Americans have fewer mood/anxiety and substance abuse diagnosis but significantly more organic/psychotic diagnoses” (p.71) Kilgus, et al described how clinicians can be influenced by their own biases and ethnocentric perceptions when diagnosing children. Although the Kilgus et al study looked at an adolescent population, the findings gave some insight into how differences in race and ethnicity may play a role in the diagnosis of children.

It is also important to keep issues of diversity in mind for they can effect changes in family dynamics. Different diagnosis such as the ones found in Kilgus et al (1994) also could effect how home-based clinician’s work with the children and families.

Development of Pre-latency/latency Age Children

The focus of the current study is on the hospitalization of pre-latency/latency age children. Therefore, an understanding childhood development at the pre-latency and latency stages is critical. The following sub sections review what has been written about cognitive development, attachment, and social development of a pre-latency/latency age child.

Cognitive Development

During the middle childhood years (age 6-12) a child experiences many changes not only externally, such as starting school and separating from parent(s), but cognitively as well. According to Davies (2004), the child evolves from an egocentric point of view to recognizing others and concurrently develops the ability to distinguish between subjective and objective reality. At this stage, children have a more accurate perception

of reality and reversibility. There is a decline in magical thinking and a rise in concrete operations. Memory improves and the child has special and visual organization (p. 387). Davies describes those transitions and changes that are occurring cognitively for the child. If a child that has been diagnosed with a mental illness that ultimately delays these cognitive changes, it can be difficult and overwhelming for a parent. Parents who then become overwhelmed and find having a child with a mental illness difficult could impact the family dynamics. It is the purpose of this study to understand how those dynamics are changed and in what capacity.

Attachment

During the pre-latency/latency years a child's attachment to his or her parent(s) begins to shift. Davies (2004) noted that the child begins to use autonomous coping strategies and primary attachment begins to shift from parents to friends in school. Latency age children find comfort in rituals that symbolize attachment, such as bedtime stories and gestures of affection (p. 386). If a child who has been psychiatrically diagnosed does not progress through this attachment phase, it can be difficult for a parent whose child has trouble separating from the parents and connecting with other students and friends. The lack of separation although at times can be endearing may soon become overwhelming for a parent, sometimes to the point when disruption occurs in the home.

Social Development

Age 6-12 is a stage when many children begin to separate from their parents and increase their orientation to peers. Davies (2004) wrote that there is an increase in social skills as children develop friendships and negotiate peer group norms and status

hierarchies. There is also an increasing awareness of gender roles and behaviors and an internalization of values and beliefs. Children at the latency stage are also able to understand separate points of views and hold two opposing viewpoints in mind (p.386). If one's child again has developed or been diagnosed with a mental disorder and is not able to progress through these necessary tasks of development, there are bound to be frustrations, disappointment, and feelings of sadness and loss. These are emotions that typically arise in parents (Marsh and Johnson, 1997) and disrupt family dynamics. It is the purpose of this study to understand the home-based family clinician's perspective of these changes within the home.

Home-Based Family Therapy

“There is good evidence that in other areas of therapeutic endeavor that home-based therapy may have advantages over clinic-based work for some patients. There are some families who have real difficulties in attending clinics” (Cottrell, 1994, p.189). Clinicians or clinic administrators are usually the ones who decide if home-based therapy will be provided to a family or not. Given this fact, it can be difficult to find a home-based therapist, making it harder for a family to receive home-based services. In addition, there are also a number of circumstances and factors that would cause a therapist to move away from home-based treatment. Despite the disadvantages of home-based therapy, there are many benefits that arise out of this therapeutic technique. Cottrell wrote, “In other fields there is evidence that home based treatments may be more effective than those carried out in the clinics. Given that most problems occur in the home and not in the clinic, it makes theoretical sense to consider home based therapy” (p.190). The

following sub-sections explore clinician qualifications, advantages, and disadvantages of home based therapy.

Clinician Qualifications

According to the Commonwealth of Massachusetts Division of Professional Licensure (2007) to become a marriage and family therapist in the state of Massachusetts and to be eligible to practice home-based family therapy, an individual must meet several requirements. The Division of Professional Licensure states that candidate for licensure must meet the following requirements to become a marriage and family therapist: 1) obtained a passing score on the national licensing examination, 2) obtained a master's or doctoral degree in marriage and family therapy and 3) completed two years of full time work experience. Full-time work experience must include 1,000 hours of clinical experience (face to face contact) and must be supervised by an approved supervisor or completed in an accredited institution (p. 3). Once all requirements have been fulfilled the individual is then allowed to practice marriage and family counseling which can include home-based therapy.

Insoo Kim Berg and Susan Kelly (2000) investigated clinician qualifications and training requirements for those employed by Michigan's Child Protective Services (CPS). Findings showed that the training models for staff, "...combined (1) 'on the job training,' which may involve an experienced peer or colleague mentoring the new worker; (2) 'shadowing,' where new workers observe experienced workers from the beginning to the end of the day to see how they handle day-to-day tasks; and (3) traditional classroom training" (p.41). Berg and Kelly (2000) who observed Michigan's CPS system for five

years and spoke with a variety of workers ranging from home-based clinicians to administrators believed that the right training and supervision were essential to the welfare of the families served. Berg and Kelly (2000) also found, after speaking with a number of CPS workers, that clinicians found case consultations and peer support a necessary aspect of the learning process:

Almost all the workers reports that they learn from the informal network they have developed on the job; thus, when they have doubts about a case, or encounter a shocking situation, they turn to each other for support, validating their perception and learning from informal discussions and consultations (pg.207-208).

Although training, both formal and informal, was an important aspect to job performance, Berg and Kelly also noted that CPS workers needed certain characteristics that would help them succeed with their families. These characteristics that included being flexible, curious, interested, respectful, having a good sense of humor, and having the willingness to realize that clients may feel overwhelmed with their presence were traits that enhanced CPS workers intervention with families during crisis (p.206). Berg and Kelly in their study of Michigan CPS workers and the difficulties and success they can face in their work make clear the training and qualifications necessary for employment. Berg and Kelly focused specifically on Michigan CPS while the current study examined a number of Massachusetts' agencies that offer home-based services. The examination and explanation of training and qualifications for clinicians allows for a depiction of those aiding families in crisis.

Advantages of Home-based Therapy

Although home-based therapy is an underused intervention, there are many benefits to providing treatment in this manner that may not be readily apparent. Understanding the advantages of home-based therapy gives insight into ways therapists conduct the therapy sessions and what new information is obtained through this unique therapeutic modality. Howlin, Marchant, Rutter, Berger, Hersov, Yule (1973) as cited in Cottrell (1994) noted, “That home-based treatment is more effective than clinic-based methods in the management of behavioural problems in autistic children” (p.190). Cottrell added that one major advantage of home-based treatment is that services are provided to families who lack transportation or have additional circumstances, such as young children or a disabled family member that makes it difficult for them to get to the clinic. The therapist also has a better opportunity to engage with the family as Cottrell noted, “The family’s knowledge that the therapist understands their plight may increase engagement” (p.192). Home-based therapy is an intervention that although underused, provides a great deal of information regarding family dynamics. This notion is based on the fact that, “The home visit may also reveal information about the family which would not otherwise have become apparent” (Cottrell, 1994, p. 192). The objective of this study is to collect data on the perspectives of home-based clinicians regarding changes in family dynamics and how they assist families to stabilize.

Disadvantages of Home-based Therapy

Home-based therapy can provide clinicians with a better perspective on changes in family dynamics, yet there are disadvantages that present when using this intervention

technique. The disadvantages related to the use of home-based therapy are important to recognize because they expose ways in which home-based therapy is a limited field. Also the disadvantages point out ways in which home-based therapy can negatively affect a clinician's work with the family. Cottrell (1994) states, "It is important to bear in mind that home visits can feel intrusive, denying families even the option of non-attendance" (p.192). Many clinicians choose not to use this intervention because they feel uncomfortable entering a family's personal space and would prefer to have them come to the clinic. Cottrell noted, "We can draw some comfort from being in a familiar place (the office) and from being in control" (p.194). Another disadvantage of home-based therapy relates to the issue of safety. Many clinicians cite safety issues as the number one reason for opting out of home-based treatment. Cottrell wrote, "Is it safe to visit families alone? – often the answer is no" (p. 194). Many of the examples that Cottrell wrote about in his article were barriers that some clinicians face when doing home-based therapy work. Cottrell added that distractions occurring within the home can have a negative impact on the therapy and was noted as a major difficulty for many clinicians. Television, video, stereo, telephone, and persons at the door are all distraction that Cottrell states can happen over the course of one session and make it difficult for any real work to get done.

Cottrell describes his own experiences as a home-based therapist and does refer to some previous research and he makes excellent points about the benefits and disadvantages common in home-based treatment. Understanding the work home-based therapists do and the challenges and successes they can face, helps frame this current purposed research study. It gives an understanding of home-based therapy and the ways families use their services.

Family Therapy

Beginning in the 1950's, family therapy developed out of an observation that forced therapists to recognize the influence of families on the course of treatment. This observation, according to Nichols (2006), was "Therapists began to notice that often when a patient got better, someone else in the family got worse, almost as though the family needed a symptomatic member" (p.10). Thus, therapists began to look for a preexisting model that could be used when treatment a family.

Group Therapy

Many clinicians turned to the model of group therapy, which paralleled the current understanding of families. Nichols noted, "Groups dynamics are relevant to family therapy because group life is a complex blend of individual personalities and superordinate properties of the group" (p.11). Yet a grouping of unacquainted individuals is very different from a family who presents with years of history, set traditions, morals, and habits. These differences required therapists to find separate techniques and ways of working with families that met their specific needs.

Group therapy was used as a beginning model for how to structure family therapy. In recent decades many ideas, movements, and individuals have influenced the way family therapy is conducted and organized. The idea of process/content distinction, which continues to have lasting impact today, differs from traditional group dynamics and has had a major impact on family treatment. Nichols (2006) defined process/content distinction as, "Experienced therapists learn to attend as much to how families talk as to the content of their discussion" (p. 13). Using process/content distinction allows for

more insight into the how the family is structured and how the family interacts. If therapists are familiar with the techniques of process/content distinction, they are able to help the family more efficiently by shifting dynamics and facilitating change.

Child Guidance Movement

Following the idea of process/content distinction, the child guidance movement had a great impact on family therapy and the focus of the work. Initially child guidance workers focused on the child and the child's presenting symptoms. Then therapists discovered that the source of those symptoms frequently had to do with the parents. Blaming the parents, especially mothers, became the focus of child guidance workers. Eventually, the emphasis of blaming the parent shifted and as Nichols stated, "This shift had profound consequences. No longer was the psychopathology located within the individuals; no longer were parents the villains and patients victims. Now, their interaction was seen as the problem." (p.16). The child guidance movement gave family therapy a focus and provided therapists with insight into family function and the benefit of including parents. Soon family therapy became the primary form of treatment in child guidance clinics and therapists began to have a working model of what family treatment entailed.

The "Friendly Visitor"

The profession of social work has had a great influence on the progression and development of family therapy. Since the beginning, according to Ackerman, Beatman, and Sherman (1961) as cited in Nichols (2006), "Social workers have been concerned with the family, both as the critical social unit and as the focus of intervention" (p.17).

The *friendly visitor* who provided family casework was an intervention technique used by social workers in the beginning years of the profession. The friendly visitor would go into the home and assess the needs of the family and offer services. Friendly visitors were taught interviewing techniques for both parents and the child to illicit an accurate picture of the family's presenting problem(s). All this took place long before mental health workers began experimenting with family sessions (p.17). When the family therapy movement began, social work was at the forefront and included many who were pioneers in the field. Social workers continue to influence the field of family therapy by educating professionals and providing families with a variety of services.

Structural Family Therapy

Salvador Minuchin, a pioneer in the family therapy movement, began his career in the 1960s. Focusing on the structure, boundaries, and roles within a family unit, Minuchin developed and followed the techniques of structural family therapy. Minuchin made great gains using structural family therapy and contributed to the knowledge of family systems and family dynamics. Minuchin's structural family therapy is used as a basis for the understanding of family dynamics and is described below.

Family Dynamics: Key Terms Defined

Many therapists differ on their definition of family dynamics and ways in which they assess and assist a family. Using family dynamics as an umbrella term for the structure, subsystems, boundaries, and roles found within a family is the focus of the following research.

Family structure is at times unseen, but is a powerful force within a family. According to Minuchin (1974), “Family structure is the invisible set of functional demands that organizes the way in which family members interact. A family is a system that operates through transactional patterns” (p.51). Families have a range of ways of relating to one another, but families can quickly fall into regular and predictable patterns where there is little room for choice or varying behavior. Families are structured into *subsystems* which are determined by generation, gender, and function. These subsystems are maintained by *boundaries*, which Minuchin (1974) defined as, “The boundaries of a subsystem are the rules defining who participates, and how” (p.53). Boundaries can provide families with either a sense of autonomy or feelings of dependence. *Structure*, including the boundaries that maintain the structure, can both be adaptive and maladaptive. Therapists can assist families by assessing the structural system within the home and shifting subsystems and boundaries so the family dynamics are healthier.

Family dynamics are influenced greatly by the roles and responsibilities held by each family member. Within families, individuals take on different roles that provide a necessary, and at times an unnecessary, function within the home. Kluckhohn and Spiegel (1954) as found in Nichols (2006) concluded, “That healthy families contained relatively few and stable roles, and that this pattern was essential to teach children a sense of status and identity” (p.24). *Roles* can be chosen or assigned, many times unconsciously, yet in either case family roles do not exist independently of each other. (p.24). Roles are reciprocal and because of this fact, behavior and interactions within the home and between family members are regulated and defined. For the therapist who

works with a family that has maladaptive roles, the goal would be to improve and modify the family dynamics by changing the roles and interactions.

For the current study, family structure, subsystems, boundaries, and roles are used as the definition for family dynamics. These four aspects of family life can create disorganization in the home and may require outside help. Structural family therapy can provide a theory that explains this disorganization and guide a therapist in their treatment plan.

Purpose and Components of Structural Family Therapy

Structural family therapy provides an organization and understanding of family life, offering a framework for family interaction. Therapists intervene in a systematic and organized way, helping families to understand their dynamics and modify their interactions. Led by Salvador Minuchin, structural family therapy has become the most influential and widely practiced family therapy (Nichols, 2006, p.172). Structural family therapy is a theoretical way to further understand family dynamics.

Structural family therapy is a process by which a therapist can analyze and interpret a family's interactions. Three constructs - structure, subsystems, and boundaries - are essential components of the theoretical formulation.

Structure: According to Nichols (2006), "Family structure refers to the organized pattern in which family members interact. As family transactions are repeated they foster expectations that establish enduring patterns. Once patterns are established, family members use only a fraction of the full range of behaviors available to them" (p. 173). As a family develops, members are assigned roles and responsibilities that maintain family

structure and interaction. The family structure is reinforced by rules and expectations. When an individual is given a role, that role is usually reciprocated by another family member who performs a complementary function. The family structure is then held in place further because the complementary role is presumed necessary. For a therapist, changing the underlying structure can have large consequences across the family system, altering the family dynamics.

Subsystems: Subsystems are a second identified component of structural family therapy. Nichols (2006) states, “Families are differentiated into subsystems based on generation, gender, and common interests” (p.174). Although more obvious separate subsystems exist (parent/child), unseen groupings can develop within a family. It is these more covert coalitions that are the focus of treatment in structural family therapy. When two groupings such as parent and child form a tight subsystem, others can be excluded including fellow spouses or other children. In these cases it is necessary for the therapist to rework the boundaries that maintain the subsystem.

Boundaries: As stated above boundaries are the invisible barriers that regulate contact with others, even within a family system. Boundaries can be both adaptive and maladaptive depending how they vary which can be from rigid to diffuse. Nichols concludes:

Rigid boundaries are overly restrictive and permit little contact with outside subsystems, resulting in disengagement. Disengaged individuals or subsystems are independent but isolated. On the positive side, this fosters autonomy. On the other hand, disengagement limits affection and assistance. Disengaged family must come under extreme stress before they mobilize mutual support (p.174).

When the boundaries are diffuse this can result in enmeshment, Nichols states:

Enmeshed subsystems offer a heightened sense of mutual support, but at the expense of independence and autonomy. Enmeshed parents are loving and considerate; they spend a lot of time with their kids and do a lot for them. However, children enmeshed with their parents become dependent. They're less comfortable by themselves and may have trouble relating to people outside the family (p.175).

If maladaptive subsystems are found to exist and are impacting the mental health and well being of the family it is the role of the therapist to create clearer boundaries among family members.

The theoretical basis for structural family therapy was presented above; the literature presented gave some information about where pathological behaviors and interactions could develop. Yet to understand the pathological behaviors and interactions more thoroughly, normal family development should be explained. Nichols (2006) states, "What distinguishes a normal family isn't the absence of problems, but a functional structure for dealing with them" (p.176). Within a family many conflicts arise both from in and outside sources. These conflicts change with situational crisis and developmental stages (p.176). The normal family, whose structure, subsystems, and boundaries are adaptive can acclimatize to these conflicts and grow and change from their experiences. Normal families can seek help during this time if necessary; yet what divides healthy from unhealthy families are the normal family's ability to modify their family structure and accommodate to the new circumstances with little trouble.

Pathological behaviors and interactions can arise in families who display a family structure that is rigid and inflexible. Nichols reports, "Problems arise when inflexible family structure cannot adjust adequately to maturational or situational challenges" (p.177). Similar to normal family's stressors and problems can arise during a family's life

time. If a family cannot adjust, change, or accommodate these situations, family dysfunction can develop.

In families whose interactions are dysfunctional, the goal of therapy, according to the structural family therapy model, is to alter the family's structure so that they are better able to solve their problems. By joining with the family, the therapist is able to realign the structure within the home so the family is better able to cope when conflicts arise.

Nichols (2006) stated, "By altering boundaries and realigning subsystems, the therapist changes the behavior and experience of each family member. The therapist doesn't solve problems; that's the family's job" (p.181). Specifically looking at enmeshed families, structural family therapy's goal is to differentiate individuals and subsystems. With disengaged families the goal is to increase interaction; goals are accomplished by strengthening and making the boundaries more permeable, respectively.

Phases of Structural Family Therapy

Minuchin (1974) outlined three overlapping phases in the process of structural family therapy. Each phase is a therapeutic technique that could be used with a family as a means to accomplish the goals. During the first phase, the therapist joins with the family; build relationship with each family member and reduces anxiety and defenses. The second phase includes mapping the current family structure. The therapist assesses the family's subsystems, boundaries, interactions, and roles. The final phase involves the therapist intervening and changing the structure to a more adaptive process (p.185). If done successfully, the therapist will have changed the structure within the home and enabled the family to face and overcome problems in a healthy and productive way.

Structural family therapy serves as one of many lenses to view and understand family dynamics. It is through this lens that family dynamics are defined and used accordingly throughout this current purposed research study.

Summary

The research currently available in the area of childhood psychiatric hospitalization, psychological diagnosis of children, and home-based family therapy is lacking. Thus, the goal of this study is to answer the question: How do home-based clinicians assess assist parent(s) who experience changes in family dynamics post discharge of their pre-latency/latency age child's first psychiatric hospitalization.

The psychiatric hospitalization of children is an area needs further exploration. What is lacking in this research is the explanation about changes in family dynamics after psychiatric hospitalization. No studies were found that give clear examples of how families change after a child returns from the hospital. It is my hope to find out more information about childhood psychiatric hospitalization, what a family's reaction to a discharge would be, and the home based therapist's response.

More studies were found that focused on individual, including parent and sibling, changes that occur after the diagnosis of a loved one. Previous studies (Flouri and Buchanan, 2002; Lukens, Thorning, and Lohrer, 2004; Marsh and Johnson, 1997) made clear that parents and siblings are greatly affected when a child is psychiatrically diagnosed. It can be assumed that the family dynamics change as well, yet there are gaps in the research addressing the overall family changes especially after psychiatric hospitalization. The purpose of this study is to present a better understanding of how

families change after a discharge and ways in which the home-based therapist assess and assist the family.

Home-based therapy and the clinicians who use this intervention have not been adequately studied. Given the sparse amount of information found thus far, I expect that this study will provide other clinicians and researchers information on home-based therapy. The question for this study involves gathering data about home-based therapist's perspectives and the ways in which they assess and assist changes that occur in the home.

CHAPTER III

METHODOLOGY

The research question for this study is: How do home-based clinicians assess and assist parent(s) who experience changes in family dynamics post discharge of their pre-latency/latency age child's first psychiatric hospitalization. This exploratory, qualitative study utilized flexible methods for research. Anastas (1999) wrote, "Flexible method research is defined primarily by the nature of the procedure used to gather the data and their origins and only secondarily by the type of data gathered, which is typically unstructured" (p. 57). My hope was to obtain rich, detailed, narrative data by using, semi-structured, open-ended questions and interviewing 12 home-based clinicians who work with families where one child has been psychiatrically hospitalized. The interview itself was semi-structured as I created the interview questions in advance. As Anastas' wrote, "There are many flexible method studies that stand alone and that describe in depth complex psychosocial phenomena in context and in ways that have never been surpassed for accuracy and verisimilitude" (p. 60). I selected a qualitative design because asking open-ended questions prompted the clinicians to tell their stories which provided a more in-depth understanding of the little researched process home-based clinicians utilize in order to help these families. My hope is that the findings of this study will not only educate others on the ideas of psychiatric hospitalization of children and the changes in family dynamics, but that the findings fill in some of the gaps in research surrounding home-based therapies and childhood hospitalization.

Sample

Given that the research question involved gathering narrative data on how home-based clinician's assess and assist parent(s) who experience changes in family dynamics, my population of interest was licensed home-based clinicians currently working in the field. I used a non-probability sample of experts because I chose to interview a specific population and the home-based clinicians were useful as study informants. I interviewed 12 clinicians. The selection criteria consisted of clinicians who have at least two years experience doing home-based treatment of families and children. Clinicians, as a requirement for participation, were also required to be licensed in their field of discipline. I also expected that my interviewees worked with their families pre, during, and post hospitalization to accurately understand what changes had occurred. The exclusion criteria included those clinicians that were not licensed and those who had not worked with a family with this situation. Diversity among the clinicians in the sample was a priority. The clinicians took part in a forty-five minute to one-hour interview where they answered several questions regarding the psychiatric hospitalization of children, the consequent changes in family dynamics, and their use of effective interventions to stabilize the family.

I located and recruited clinicians from agencies that provide home-based counseling. I contacted those agencies that were known to me and I also accessed the telephone book and called agencies to find out if they provided these services. If the agencies did provide home-based services, I contacted the director of the agency by first sending out an informational letter (Appendix A) that stated the purpose and process of my study. At this time I also provided the agency director with information regarding the

Human Subjects Review (HSR) board and asked if they have an Internal Review Board (IRB) that needed to approve the study. If the agency director felt his/her agency needed to approve the study I submitted the requested material and waited for his/her approval. Once the director of the agency provided written permission, I then contacted the clinicians through phone, email, or letter who meet the qualifications of the study and asked if they would be willing to participate. Once they contacted me I set up a time to interview.

There were bound to be some feasibility issues given the limited number of home-based clinicians. Home-based therapy is an intervention that not many agencies or clinicians offer. Therefore finding clinicians who have the time, motivation, and availability to participate in this study might have presented some problems. If I found that it was too difficult to access home-based clinicians, my next step was to contact outpatient clinicians who work within a clinic and who worked with the families of psychiatrically hospitalized children. If this strategy also failed to bring enough participants, my last step was to interview supervisors who have had supervisees who have treated families with psychiatrically hospitalized children. Although it was important to have a backup plan when beginning a study, I was able access appropriate contacts and I did find 12 home-based clinicians who were willing to participate. Another feasibility issue was that the focus of the study was on the hospitalization of a child. It could have been difficult to find therapists who have had such cases and experiences. The limited amount of childhood hospitalization could cause issues when attempting to find the population I wanted to interview.

Ethics and Safeguards

Although mental health clinicians are not considered a vulnerable population, the information that I collected from the clinicians did involve children. Therefore there were many safeguards that needed to be identified. Confidentiality was maintained by numerically coding all data and storing this data in a locked file for a minimum of three years as consistent with federal regulations. The home-based clinician's names as well as any case examples were disguised. The clinician's name was never associated with the information provided. The data that was generated from this study could be used in other educational activities as well as in preparation for my Master's thesis.

There were both benefits and potential risks associated with the home-based clinician having participated in this study. The benefits included the clinician knowing that they have contributed to the knowledge of family systems and how psychiatric hospitalization of a child impacts a family. There might have been a benefit for clinicians to tell their story and have their perspectives heard. There were also some potential risks including that participation in this study might have evoked strong or uncomfortable feelings while the clinicians shared their experiences. Unlike other populations, mental health referrals were not necessary when mental health professionals comprise the sample.

Data Collection

I began data collection after the Human Subjects Review committee granted approval of my research study (Appendix B). I contacted those agencies that 1) were known to the research and 2) were found within the local telephone book. All agencies provided home-based therapy. I then asked for permission from the agency director to

interview the current home-based therapist working out of that clinic. When the agency director signed and submitted the letter of permission, the clinicians were contacted and asked to participate in a study that examined the psychiatric hospitalization of children and changes in family dynamics. Twelve clinicians who were interested and qualified agreed to participate. Dates, times and locations for interviews were scheduled, either in person or over the phone. Prior to the interview, clinicians were given two copies of the informed consent (Appendix C). They were asked to review the form, sign one copy, and keep the second for their records. Informed consent was then collected before the interview.

The interviews ranged in time from 45-minutes to one hour. The interview guide (Appendix D) consisted of self-developed semi-structured open-ended questions to elicit rich, narrative responses from the clinician. The interview questions were divided into several sections including: demographics, family systems, agency protocol and service, case example(s), family functioning, interventions, stabilization, and terminations. In order to increase reliability and validity, I had two expert reviewers (individuals with more than five years experience in the field) review the interview guide and provide feedback and suggestions. This feedback was incorporated into the final interview guide. In-person interviews provided the researcher with an in-depth, narrative text that went into great detail about what the clinician has seen and attempted to do in order to stabilize the family. Because the term *family dynamics* can have different meanings among clinicians, conducting the interview allowed participants to share their understanding of family dynamics and how they have observed and experienced changes within a home. Anastas (1999) states, “People are often more willing and able to reflect at length on

complex feeling, understandings, and past experiences through the spoken word then a written one” (p. 351). Data collection was aided with the help of a tape recorder along with a notebook for thoughts, ideas, and reactions.

Data Analysis

Data collected from each interview is presented in the *Findings* chapter. Each interview was tape recorded to ensure accuracy of information and data. During the interview and during the transcription process, a notebook was used to record thoughts and ideas regarding the data. I personally transcribed each interview, which allowed me to maintain confidentiality and review the material a number of times which, in turn, enhanced my understanding of the data. Once the transcriptions were done, demographic data was coded to protect confidentiality and the narrative data was analyzed by assessing similarities and differences.

The process of data analysis involved grouping responses into similar themes, words, and ideas as well as making note of differences among responses. This data organization was done by reviewing each transcript individually and creating separate computer files for each question. Once the data was thoroughly reviewed, similar or unique answers were cut and pasted into each file. The files made accessing information quick and efficient. Having all the responses and data in one location helped with organization and confidentiality.

CHAPTER IV

FINDINGS

Introduction

This chapter presents the findings from the twelve interviews conducted with home-based family clinicians. Each clinician had at least one case where they provided home-based therapy to a family with a latency age child who was psychiatrically hospitalized during that time. During content theme analysis of the data it became clear that despite working with a variety of different families and situations, many similarities emerged in the clinician responses. Perhaps the most prominent theme that emerged was the relief from stress and the break from the child's behavioral aggression that parents experienced during the time of hospitalization. Clinicians made reference in their case examples to the fact that parents experience a sense of relief when their child is hospitalized, despite the fact that that relief is frequently accompanied with a sense of sadness and loss. A second theme found within the data included the idea of a "honeymoon" period after the child returns home. Many of the clinicians stated that when the child was discharged and returned home, there was an initial absence of negative behaviors. However, in many cases the child's negative behaviors eventually returned. A third major finding had to do with the number of hospitalizations each child had experienced and the length in time in which the child was hospitalized. A number of the children had experienced more than one hospitalization and some of the children had been hospitalized for several months before returning home. Although these are only a

few of the findings, more themes were apparent in the data and will be reported later in the chapter.

The twelve participants were asked questions that were designed to elicit their clinical experience with family systems, interventions, family stabilization, and termination. The questions were both open and closed ended beginning with demographic information and the home-based clinician's definition of healthy family functioning. These questions lead into a discussion of agency protocol and a case presentation. Once the case was presented the clinicians answered questions regarding family functioning during and post hospitalization and specific interventions used by the therapist. Finally clinicians were asked to comment on family stabilization and termination.

The questions were designed to facilitate a discussion between therapist and researcher. The findings will be reviewed in the same order in which they were asked. The data from these interviews will be presented in the following sequence: demographic data, family system, agency process and disposition, case example, family functioning, intervention, stabilization, and termination.

Demographic Data

The participants in this study included twelve home-based clinicians; eleven women and one man. All clinicians resided in Massachusetts and worked solely with families who also resided within that state. Twelve clinicians came from three different agencies, each agency specialized in home-based family and individual therapy. The participants ranged in age from 25 to 56, with the majority (n=7) being over 30. All clinicians identified themselves as Caucasian with a variety of ethnicities including:

English, Ukrainian, French Canadian, American, European, Welsh, and German. Two clinicians did not identify an ethnicity and some of the participants (n=5) identified their ethnicity as American.

The following section presents information regarding the clinicians' education and specialized training. Degrees obtained by participants included: seven clinicians with a master of social work (MSW), four of the seven were Licensed Independent Clinical Social Workers (LICSW), three held a masters of counseling psychology, one with a doctorate of ministry in marriage and family counseling, and one clinician held a bachelor of arts (BA). Although the BA did not meet requirements for participation, given the number of years the clinician had in the field (10) and the case she presented, an exception was made. Three clinicians noted that they had received specialized training in family systems or home-based therapy. This training included: hospital crisis prevention, reactive attachment disorder, adoption, Minuchin family systems therapy, and brief strategic therapy. One clinician stated that he had 20 years of experience doing ministry work. Four therapists mentioned that they had taken graduate level courses that focused on family therapy. Two participants reported that they had no specialized training, and two clinicians did not respond to that question.

The number of years in the field ranged from 2 to 25, with the majority of the participants (n=8) having five or more years of experience. Participants' current client caseloads varied in number. Therapists who were engaged in a supervisory or administrative role (n=2) in the agency carried 1 to 3 cases, although one clinician stated that she supervised 50 to 60 cases in addition to her own. Other participants reported the following number of cases: 12 to 14, 12 to 18, 8 to 10, 10, 10 to 12, and 16. Two

therapists carried 7 cases and one clinician, who stated he worked part time, was assigned to 2 cases. Clinicians were also asked to report on number of current cases with psychiatrically hospitalized children. A few clinicians (n=3) reported they currently had only one child who was hospitalized. Other clinicians responded: 10, 5, 4, and 2. Finally one clinician stated all her cases involved hospitalized children.

Family Systems

This section details participants' responses to questions pertaining to family functioning and family dynamics. Clinicians were asked to 1) identify criteria for a well functioning family system and 2) give a profile of a well functioning family.

Well Functioning Family: Definition

In response to the first question regarding family functioning, clinician's answers showed a number of similarities. The most common response to this question was the idea of having positive communication within the home and between family members. A number of the clinicians (n=7) felt that in order for the family to function well, family members needed to communicate with one another and resolve conflict appropriately.

This therapist described the need for positive communication best:

I think one of the biggest things for a well functioning family system is they have elements of positive communication and positive understanding of the other family members. I think it is important to know that every family is going to argue and there is going to be conflict, but for a positive functioning family they have the skills, ability, and the desire to work out those kinks and conflict can be resolved in peaceful manner.

Although the majority of the clinicians felt that communication was the foundation of a family that functions well, it was not the only response. Other clinicians (n=4) identified

structure and appropriate boundaries as an essential part of a family that functions well.

One participant made clear the importance of boundaries:

If there are two parents, parents are on the same page. They work collaboratively, they have good boundaries they are not sharing their relationship with their children. Same thing with the siblings, each of the systems has decent boundaries. They are somewhat permeable so they can invite others in, but that they are not that rigid, but that they are not that soft that anything is allowed in.

Two clinicians who identified boundaries and structure as an important aspect of home life also felt that flexibility is important when setting limits. One clinician stated that for a family to function well, it was important for parents to be able to adapt and grow with their children. The second clinician reported that families have to be able to adapt to changing circumstance in order to promote growth and stability.

Although communication and boundaries were the focus of most participants' first response to the question, many clinicians identified additional and necessary aspects of stable family functioning. One of those aspects was safety. Three clinicians stressed the importance of safety in the home; one clinician stated, "My rule of thumb is usually around safety so long as they are not getting hurt or hurting themselves and they don't have an intent to hurt anyone else, if you got that, then you are probably at 50% of the way." Aside from communication, boundaries, and safety, clinicians also identified well functioning families as those who 1) act in the best interest of the child, 2) establish positive expectations for the family as a whole and for its individuals and 3) emphasize respect for each member.

Well Functioning Family: Profile

Within this section of the interview guide, clinicians were also asked to describe a family that functions well. Similar themes emerged in response to this question as in the last including communication and boundaries. Nine clinicians used communication as their descriptor for a family that functions well and three clinicians identified boundaries.

One clinician described communication for a family that functions well as:

I see that happening when, whatever the dominant communication style of the family and everyone has bought into it. For some families that means open/fluid communication, but for others the communication style is not open, but as long as the rest of the family is ok with that, it works. As soon as one family member tries to communicate in a way that does not work for everyone else, that is when you can see disruption.

Several clinicians (n=5) went on to explain the importance of communication during conflicts particularly in the presence of outside stressor, such as a child's illness. One clinician determined that for a family to function well, "able to communicate across the board, throughout all types of experiences and challenges." Many clinicians also noted the importance of having everyone's opinion valued and respected.

Again, boundaries were a theme that emerged in response to the second question of this section. Three clinicians felt it was important to have "parents in the lead," while one clinician stated, "children are separate from selves [parents]." These situations were maintained by setting boundaries between parents and children

Along with communication and boundaries, there were a variety of additional responses. A description of a well functioning family included: a nurturing environment, safe, basic needs are met, and the mentality that each individual wants to be part of the family.

Many clinicians shared similar ideas when responding to these two questions. Only one clinician had a response that was unique and unlike any other. She mentioned both in her description of a well functioning family system and a family that functions well that a family should be, “actively involved in the community.” This clinician believed that an active involvement in the community was an important factor to family function and created an important connection to others.

Agency Process and Disposition

In this section clinicians were asked to explain their agency’s protocol for conducting assessments and determining service delivery. All twelve clinicians came from three home-based agencies and all agencies were contracted through the Department of Social Services (DSS).

In response to the first question all clinicians (n=12) stated there was a standardized form that asked a variety of questions about the identified client (IP) and the IP’s family. Clinicians ask the parent(s) about strengths, stressors, family history including: substance abuse, psychical, emotional, sexual abuse, medical history, and mental illnesses. The standard form, which for one clinician was 35 pages long, asked about current household members and the IP’s relationship to these individuals, how the family was referred to the agency, and current systems involvement. For two clinicians this protocol took about an hour and a half to complete. For nine clinicians the assessment was completed within the first two sessions. One clinician had 21 days to finish the assessment.

This clinician sample was recruited from three agencies. Thus, there was little variation in their assessments. However, one clinician mentioned an idea that other participants did not – keeping in mind the family as the expert:

Then when I go into a house I go in with the assumption that the family is the expert on what is going on. I am there to help put things into words, but the family knows best and I think it is important to remember that and not to go into assumptions. In general, letting the family know I am there more as a mediator and to assist them with what they already know. I am there for them and not against them.

Although other clinicians (n=3) mentioned both family and individual strengths as part of the assessment, this respondent was the only one who stressed allowing the family to be the expert and take the lead on what services they needed and wanted.

Clinicians in this section were also asked how their agencies determine the amount and type(s) of service delivery. Again because the clinicians were employees of only three agencies there was little variety among their answers. Six of the twelve clinicians stated that the insurance agencies and/or DSS determine the type of services a family receives, not the home-based agency. One participant added that therapists can make recommendation about services, but that the insurance company or DSS has to agree with those recommendations before services be changed or supplemented. Three clinicians stated that the parents can self refer and request those services they feel would be beneficial to their family. Two clinicians stated that in order to receive services the child has to be at risk, either psychiatrically hospitalized or placed in an alternative setting. Finally, another clinician noted that in order to receive home-based services from her agency, the child has to have been hospitalized or is currently hospitalized.

Case Examples

In this section clinicians were asked to provide one case example of a family pre, during, and post hospitalization. The twelve cases were both similar and varied and presented with an array of behaviors, family histories, and hospitalization.

Participants reported working with these families from three months to one year. One clinician added that she was still working with this particular family and therefore the case was currently open. All families were provided with family stabilization services by the home-based clinician. Two clinicians reported working with the family alone, while ten clinicians were paired with either a master's level or a bachelor level co-therapist. The ages of the child clientele described by the participants ranged from 7-13 years old comprised of four females and eight males. Three children came from single parent homes. Three came from a two parent household, in which one partnership involved two women. Two children lived with their grandparents. Four clinicians did not address the family composition. Six of the children had siblings, while three were only children. Three participants did not mention if there were siblings in the home.

Five families showed a history of mental illness, specifically a diagnosis of depression, ADHD, bi-polar, and personality disorder (n=2). The reasons for hospitalization included aggressive behavior (n=11) and depression with cutting (n=1). The most common aggressive behaviors, in nine out of the twelve children, pre-hospitalization were hitting, tantrums, throwing objects, fighting with siblings, and yelling. Some of the unique behaviors exhibited by three out of twelve children included cutting, sexually acting out, throwing feces, and running away.

The length of time the clientele remained in the hospital varied from 1 week to sixty days. While hospitalized, the therapists reported that six of their clients were started on medication or had their medications adjusted. During hospitalization, a few of the clinicians (n=4) continued to work with the family. Treatment intervention included: marital counseling, installing structure, working with parents around safety and expectations, and meetings at the hospital with hospital staff. Once their hospital stay was finished, the child was discharged to the home (n=5), to a day program (n=4), to a residential program (n=2), or to partial hospitalization program (n=1). During this time all clinicians (n=12) reported that they were able to continue working with the family.

Family Functioning

Clinicians were asked to describe observed changes in family functioning during and after the hospitalization. There were many surprising similarities and differences in both the reaction of parents during and after the hospitalization.

During the period in which the child was hospitalized it was clear that, despite each clinician reporting on a different family, there were similarities in their [the family's] reaction to the hospitalization. Many parent experienced relief around the stress of having a child hospitalized (n=5). One clinician clearly described the impact on family function caused by having an aggressive child taken out of the home, "Families tend to function better when their child is in the hospital, in some ways. Parents tend to get a little more sleep, siblings are less on edge, and everything seems to be a little more settled." Another clinician recalled the change in quality of life experienced by one mother:

She also expressed that she was a little relieved not to have to worry about him getting up in the night and doing something dangerous. He had at least one suicide attempt, so she was relieved about that and also she had begun dating a guy, why he was in the hospital and which is something she wasn't able to do because no one would baby sit him because he was so aggressive. Her quality of life went way up when he was in the hospital.

Other clinicians reported their families expressed that things were “calmer,” while another clinician stated that her family felt that they got a “break from the chaos.” One clinician added that despite the relief families experienced during this time their child is still out of the home and that can evoke a great sadness in parents, “There is definitely a sadness and emptiness, they miss this person, they don't miss the behaviors, but there is a tangible thing that is missing.”

In addition to feelings of relief, another theme emerged related to the reaction of parents during the hospitalization - parental guilt. One clinician made clear how and why parents can experience this emotion, “Because the hospitalization tends to give the family a break, a lot of parents feel guilty not that they don't miss their kid, but they don't miss the stress of having that child at home.” Another clinician also observed parental guilt as she replied, “Mom did a lot of questioning like ‘What did I did wrong?’ so it really threw mom for a loop... so we had to do a lot of work around mom's guilt.” A third participant described her family's concern over responsibility and guilt:

A lot of time a family has guilt. Guilt over did I do this to my child and a lot of the work is explaining to them that this is a mental illness and even if your child was born somewhere else these symptoms would still be there. It is not the environment. It is a different kind of child we are talking about and parents feel responsible for that. But all you can say is that they are not responsible for that, it is a mental illness and you can't control it.

In a few of the families where there were siblings of the hospitalized child (n=3) clinicians reported that parents were preoccupied. This preoccupation impacted their

ability to parent the other children to the point where siblings experienced a lack of attention by the parents. One clinician described the impact a hospitalized child had on other family members:

When she was hospitalized, Mom really freaked out and the client became the center of her universe. And we spoke with Mom about how that impacts her ability to care for her two other children, how it affected her mentally, and how it was really draining... So we really had to work on what it means to be a mother, how are you feeling, and when you need to be there and how you can be there without not physically being there for her because you have two kids at home.

Another clinician reported that with her family the siblings were “suffering from lacking a lot of attention” and had to care from themselves.

Although many of the participants reported similar occurrences during the hospitalization, there were a few families who had unique experiences. One clinician stated that the hospitalization threw the family she was working with into a more chaotic situation, “The middle child stated to escalate somewhat. The youngest was the peacekeeper, trying to keep everyone happy and the middle one was just frustrated. Mom had to give up her part time job; dad was frustrated every time he had to leave his to come to a meeting.” Other clinicians (n=2) reported that their families experienced fear and anxiety over the hospitalization. One clinician stated that the family was “freaking out,” while another participant stated the family she was working with had a “funeral feeling.” The clinician further explained the reasoning behind this situation:

But it also felt like there was somewhat of a funeral feeling because this family associated an inpatient stay with, “We are going to lose her, she is going to be lost to our family,” due to the older daughters year long out of home placement. I know that mom and the little girl were acutely afraid that they were going to lose her.

Clinicians' were also asked to describe changes in family function after the hospitalization. Clinicians observed a number of different outcomes after the hospitalization. Some outcomes changed families for the better, while others families returned to how they functioned pre-hospitalization. Four clinicians reported that after the hospitalization things became more stable and the family functioned better. One clinician described the difference the hospitalization made to her clients:

What ended up happening was the child came home stable, more stable from a mood perspective especially after a few weeks. The meds seem to really help uplift her mood. Everyone reported less fighting, less irritability, her affect improved, her energy really changed and you could see the family really breathe a sigh of relief around the difference in mood.

Another clinician also observed a change in her family, "I think one thing that changed was that the grandmother did a really good job in trying to adapt to the suggestions of the hospital. She was able to respond to him when he was getting heated up and needed to take some space. She was able to stay really calm." A third clinician stated that when the child returned home, things were "back to normal" and the "parents had more control." Other participants (n=2) reported that for their families there was an initial change in family functioning and that things were calmer, but soon old behaviors reemerged. Families were unable to maintain these changes and returned to how they were functioning pre-hospitalization. One clinician stated, "After he came home for the first few days things were fine and then things started to go south." Another clinician observed the same situation after the child was discharged from the hospital:

So when he came home from the hospital it was not easy. I believe he was better and in return the family was better, but there was so much anger and resentment that the family had a hard time readjusting. When he was in the hospital the family definitely felt like things were calmer, but when he came home things were good for awhile, but it was difficult.

Two therapists stated that their clients experienced more anxiety as a result of the discharge. One participant reported, “Grandmother was also a lot more anxious after the hospitalization just wanting to keep him safe and feeling guilty that she had been involved in his life and feeling guilty letting him go back several times to live with mom.” A second participant made clear the thought process parents can go through after their children has been discharged from the hospital. The focus was on anxiety and the uncertainty parent can experience:

After the hospitalization, the anxiety returns. The parents think, you know, what if this time it is different, is this going to work? And then there is the thinking well maybe it won't. The first sign of anything that makes them go back there; they start to think that maybe they will have to go back to the hospital. There are some things that get better, but the parents are sad. But the anxiety returns and I think that it is more that they don't feel satisfied. Like if the kid seems the same to them, then they are angry that the system is not helpful. But if the kid got better, sometimes it is like expected that things will go well. But I think it is not always expected to go well. It is very different depending on the severity of the illness and the way it is managed. They go back to what they were doing.

There were many similarities in the participants' responses when describing family functioning after the hospitalization. Hospitalization can cause families to stabilize, stabilize briefly, or evoke more anxiety. One clinician held a different idea in that she believed that having a child hospitalized changes nothing and only family therapy can change how a family functions:

I don't see a lot of changes in dynamics unless the child is out longer term and the family is able to settle down from being in crisis, or there is a drastic change and the child comes home the model child. So it is not until there is family therapy going on, that is changing the way people think or how they speak to each other. The hospitalization itself may shift things, but it is not going to change dynamics.

Interventions

In this section clinicians were asked to describe those specific interventions provided to the family and then describe the impact of those interventions. Depending on the length of time the clinicians worked with the families, 3 months to one year, clinicians provided a variety of interventions to the family. These interventions varied among the participants; there were some similarities among clinicians, and also a number of differences. Psychoeducation with parents and siblings was the most prominent (n=4) intervention technique provided by the home-based therapists. One clinician described how she used psychoeducation with a family, “We also did some further psychoeducation and exploring of feelings and planning around the mood disorder. What is that going to look like on a day to day basis, so she would never get to the point where she would have to be hospitalized again” Another clinician provided psychoeducation around drug abuse, while a third clinician educated her clients about the new diagnosis. The fourth participant stated, “With grandma we did a lot of psychoed stuff, she had been doing the best she could, but sometimes your instincts around that type of thing are not always the most productive response.”

A second intervention that was frequently used by participants (n=3) was contracting for safety and creating safety plans with families. Depending on the reason many of these children were hospitalized, eleven with aggressive behaviors and one for depression with cutting, clinicians believed it was essential to have safety plans in place for when the child returned home.

A third intervention that was also commonly utilized by many clinicians was helping families and individuals develop more effective coping skills. Two clinicians

worked with families to help them cope more effectively with their child's aggressive behaviors, stress, and a new diagnosis. In conjunction with coping skills, one clinician helped the family learn grounding techniques and how to deescalate a crisis situation.

As stated above, there were a number of interventions provided by the participants with some clinicians implementing two or three techniques. Many of the interventions were found in a number of the cases, as stated above, but others were unique to each case. Those specialized interventions included: setting limits with parents, anticipated grief and grief work, hand-holding, marital therapy, collaborative problem solving, systems work, token economy, family work in conjunction with the hospital, practicing positive communication, getting parents to ignore problem behaviors, debriefing/discussing client experience of hospital, and cognitive behavioral therapy. All these interventions involved the family.

However, there was one intervention that was considerably different from the rest in that this strategy involved no family work at all. One clinician decided to forgo working with the family and focused her attention solely on the identified child and the relationship he had with his family. Her response when asked about specific interventions was:

Well all my interventions were solely around the patient. I worked with him and the relationship he had with his family. I worked with the hospital and helping him with the transitions and working with the family around the transition. Looking back perhaps it would have been better to work more with the hospital and their treatment plan. To involve the family more around how to transition him home.

This participant was the only clinician who worked solely with the IP. One other clinician in concurrence with other applied family interventions also arranged for an individual mentor for the identified client.

Stabilization

Clinicians were asked whether the family had stabilized and over what time period. The majority of the clinicians (n=10) responded “yes,” while two therapists stated “no” their families had not stabilized. For those therapists who responded “yes,” each provided a follow up explanation. Two clinicians acknowledged that their families had stabilized, but they were unsure of the permanence of this stabilization. One clinician replied, “I don’t know if they will stabilize forever, but when we left they were in a much better place and able to maintain then when we started.” The other clinician gave a similar answer:

I think stabilize is a different word to different people. Families still need services after I leave, but I leave them in a better position than when I came in. I have a couple [of families] that have gotten worse because they were not ready for treatment. But I would say most stabilize to whatever level they can reach at that point. When I close a case or transfer they are at a point where the crisis is over, will it come back, I don’t know. Have they learned skill yes, can they apply them, maybe.

Two other clinicians, who answered yes, found that stabilization occurred within the first few days, but soon the family again became unstable. One participant stated, “I would say they did, at least immediately. Because he [the child] left the hospital stabilized and in return it somewhat stabilized the family. Yet as time went on, it became more difficult”. The second clinician found a similar occurrence in his family, “For the first few days they were ok, but then he [the child] stated acting up.”

Other “yes” responses by participants varied from observing that complete stabilization to noting that more work was needed. One participant answered, “I would say he did..., it does not look like he will have to be hospitalized again.” A second clinician stated, “At that time yes...They stabilized to the point where they could keep her safe in the home. But then as far as helping her thrive, I thought more work had to be done, but that was left to people we put in place.” Another therapists recalled, “The family stabilized to some degree, but I think only to the degree that someone would expect from the stabilization of the mood of this one kid.”

Two clinicians, when asked whether the family stabilized or not, answered “no.” One clinician stated that stabilization did not occur due to the fact that soon after the child was discharged from the hospital had to be transitioned into another home. Therefore the family never had the opportunity to stabilize. The second clinician recalled:

No, I guess you have to thank what stability is. Yes they stabilized without him; yes I think mom is still really sad. She called a while ago to update me and said things were the same, but my other children are doing better because he is not here. Which is really sad. To think you have to remove one of your family to make the rest of the family stable is a really sad thing.

Clinicians were also asked to determine how long it took the family to stabilize. Out of the ten clinicians who answered that the family did stabilize, the length in time ranged from “almost immediately” to six months. Two clinicians followed up their response with an explanation. One clinician stated:

It did take a lot of time; we worked with the family for about 3 months and it probably took mom about 4-5 weeks to get a handle on when it was appropriate to be there, when should I hold back, when should I call. It did take a couple of weeks for her to feel comfortable and for the client to feel comfortable.

The second clinician mentioned the outside factors that helped make stabilization happen, “Because he was hospitalized for over a week he was ready to come home and they got back to what they needed to do without it being complete chaos. Plus school had just ended so that helped.”

Termination

In this section clinicians were asked to describe the termination process including the family’s reaction was to the termination as well as the clinician’s reaction, and how did the termination occur.

In response to the first question, describing the termination process, participants terminated chiefly because the client’s goals had been met. Yet their experience of the termination process varied. Eight clinicians reported that termination occurred due to the family meeting all their initial goals. Some clinicians then went on to further explain how termination occurred. One clinician recalled, “We terminated because the goals of the initial referral for in-home service had been met.” This clinician then continued to describe how she reviewed the progress the family has made, “What I typically do is a review of where we started and where we ended up.” The other participant whose case also closed because of goals being met experienced some hesitation from the family:

I wanted to terminate before the parents did. I thought they were ready, but Mom continued to hold on. We had meetings every six weeks with DSS, which kind of laid out what we needed to accomplish before we could close. Mom knew we needed to get community services in place for marital therapy and for her daughter. Once she knew they were in place, she knew the case was going to close, but she wanted us to stay longer because she wanted home-based therapy.

The third clinician terminated by giving the family one months notice and then gave a pizza party to “make it a little more upbeat” during the last session. Another participant

stated that that her family was “ready to close,” having met all goals and stabilized after the hospitalization.

Two clinicians disclosed that the termination process was not exemplary, with one participant self reporting that this was his worst termination. Despite meeting the goals outlined during the initial first sessions, these clinicians were disappointed in how termination occurred. One clinician recalled:

Termination was not exemplary. One, they had been meeting with our team and the other clinicians. We spoke and it appeared the services were really redundant. So we had a joint session and it seemed to us it was better to work with [the other clinicians] because they had longer terms services. Grandma said that made sense and said goodbye.

The second participant reported a similar reaction to the termination:

It was probably one of the worst terminations I have ever done. I got the feeling that the mother was going to say I never want to see you again and I wanted to have some closure. So I pressured her to meet with me and she was on the street waiting for the bus. There were other people around. So I gave her the referral information and talked with her briefly about the referrals and made sure there would be continuity with his care and that he was going to see a therapist and continue with his meds. I had her sign the paper and I left.

Some participants (n=4) were unable to terminate with their families for a variety of reasons. Two clinicians were unable to terminate because the identified client was no longer at home and therefore services were immediately terminated. One clinician recalled, “They understood it was a natural progression and since he was not in the home there was no need for us. My kid was the identified client, but now the kid was not here you don’t need to be here, but I think there was some sense of trauma in this family.”

Another therapist had a similar situation with her case. The identified client in her case had been transitioned to another placement, therefore she was unable to terminate. In one

case, the participant recalled, that termination occurred because the insurance authorization ended.

This [case was] terminated when the insurance authorization ran out. I spoke with our reviewers and sort of let them know what was going on. The insurance wanted us to stay in because they thought when the client does go home they are going to need family therapy. So we checked in with the insurance reviewer and let them know the client would not be going home any time soon. So we let Mom know. And we closed the case only with the option that FST can be brought in again.

The fourth clinician has not terminated because she is still currently working with the family.

Participants were then asked to describe the family's reaction to the termination. Four clinicians reported that their families were saddened by the termination. One clinician stated, "They were sad, but grateful." A second clinician recalled that her family was understanding about the termination but sad both over loss of their son who, by that time, had not returned home from his second hospitalization. Two other clinicians also reported that their families were emotional during the termination.

Three other clinicians reported that their families were ready for termination and that they expected that services were coming to an end. One participant reported that her family was ready and she shared her concerns about staying in longer, "They were ready for it. I think dad was ready to break out on his own. Mom relied too much on the providers for coaching rather than taking the reins and parenting herself. It was time to back out because we would have been parenting the children." A second clinician simply stated, "They were ok; I think they wanted longer term services." The third clinician had a family who expected that home-based services were ending, "They had expected it, we had talked about it and Mom was apologetic that we couldn't meet and had some idea. I

mean it was not the typical FST model..., but they were appreciative and certainly understood where we were coming from.”

Other clinicians described a variety of responses from their families. One clinician found that her family was hesitant to terminate, while two clinicians stated their families were “fine with it.” Two clinicians did not report on the family’s reaction to termination due to the fact that neither clinician was able to terminate their case.

Clinicians were then asked to describe their own reaction to termination. The responses from the clinicians varied. Three clinicians reported that they were ready to terminate. One clinician described her feelings at that time, “My honest reaction was [that] I was just exhausted by the case. Mom was tough to work with, and it was difficult to get her to change things.” A second clinician mirrored the feeling of exhaustion, “We were ready, we had this case for so long and we couldn’t do anything. It was rough.” The third, who again gave the look of fatigue when speaking about her case, participant simply stated “we were ready to close.”

Three participants had a different reaction, they experienced sadness. One therapist recalled, “My reaction to termination was interesting because I really liked each member of this family, which is not always true. So I have a lot of sadness about letting go of them because they were a really a cool family...” Similarly, a second clinician had experienced some sadness when terminating. She stated, “We are a very intense program, we become somewhat incorporated in the family system, especially for single moms. Therefore it can be difficult for us to leave because you are so involved in the family.” Finally, a third clinician also mentioned this feeling of sadness, “Well that was hard; it was harder for me. A lot of confusion over what could I have done differently, why did

this happen. It is sad for parents because they look at us and they are like you were supposed to help us and you didn't and we are like yeah you are right." Along the lines of sadness one participant summed up his experience with termination in one word, "terrible." While another clinician found the termination "frustrating."

On the other hand, two clinicians described the termination as positive. One clinician stated, "I was happy. I felt good. You know I helped the family out, even if it was just a little."

Two clinicians were unable to terminate, because in one case the child was transitioned out of the home and in the other case, the clinician was still working with the family.

Ten clinicians identified their termination as formal, while one clinician did not identify how termination occurred due to the case still being open. Another clinician stated that because her case ended so abruptly with the child not returning home, she did not identify how the case terminated.

Summary

This chapter presented the findings that emerged from fourteen questions asked to twelve home-based clinicians. Each clinician had over two years of experience, with the majority having over five years and all but one participant had obtained a master degree. Each therapist had worked with a family pre, during, and post hospitalization, providing home-based therapy to the identified client and their family. In response to most questions asked during the interview, clinicians had a number of similarities in their replies, specifically having to do with family systems and stabilization. However there

were some clinicians whose responses differed from their colleagues, most notably in response to case example and reaction to termination.

During the interview participants were asked to describe a well functioning family system; overwhelmingly the clinicians agreed that communication in the home was necessary. A number of clinicians also felt that boundaries and safety were an essential aspect to family functioning. These themes emerged again when the clinicians were asked to describe a family that functions well. In response to agency assessment, a number of the clinicians used the standard agency assessment form and again, the majority of the clinicians responded that their agency had little impact on determining the type of service a family would receive.

Clinicians were then asked to give a case example, which varied given the different locations, ages, and make up of each family. Despite these variations, there was one similarity found within each case that had to do with how each child was hospitalized. Eleven clinicians stated aggressive behavior was the determining factor for hospitalization. Participants then reported on how the family functioned after the child returned home and described the changes they observed. Overall, some clinicians noticed that family functioning improved post discharge; but for others there was either an immediate positive change that soon reverted to pre hospitalization functioning or no change at all. Intervention strategies varied depending on the length of time that the clinician worked with their family. The most common intervention was psychoeducation. One clinician decided to forgo family therapy and focus on the identified client and his relationship with his family.

Participants were asked to recall if the family stabilized and over what time. The majority of the participants stated that indeed the family had stabilized, and in a span of one week to six months. Finally, clinicians discussed the termination process. Most clinicians terminated because the initial goals had been met, while other clinicians were unable to terminate or had to terminate due to insurance mandates. Most clinicians stated their clients were saddened over the termination, but appreciative of the help. When asked to describe their own reactions most clinicians were ready to terminate, but also found it hard to let the family go.

CHAPTER V

DISCUSSION

The objective of this study was to determine how home-based clinicians assess and assist parents who experience changes in family dynamics post-discharge of their pre-latency/latency age child's first psychiatric hospitalization. Through the combination of literature and narrative text, provided by twelve home-based clinicians, childhood psychiatric hospitalization and the impact it has on family dynamics was explored.

Throughout the interview process, despite each clinician working with a different family, similarities emerged both in the family's experience of the hospitalization and in the therapeutic services clinicians provided. This chapter presents those findings in the context of the literature reviewed as follows: 1) key findings, a comparison of this study's current findings with past literature; 2) implications, a discussion on how the field of social work can incorporate the findings into practical use; and 3) recommendations for future research in the field of home-based family therapy.

Key Findings

A family's experience of a child's psychiatric hospitalization and the clinician's response was explored through the narrative text of home-based clinicians. This section reviews those findings in comparison with the previous literature. This section is divided into the following sub-sections: demographic data, family systems, agency protocol and

disposition, case example, family functioning, interventions, stabilization, and termination.

Demographic Data

Twelve home-based clinicians participated in this study, eleven women and one man. Clinicians ranged in age from 25 to 56 and all identified as Caucasian. The participants all practiced in Massachusetts and carried a case load that ranged from two to seventeen. Each clinician had at least one case in which a child had been hospitalized. Clinicians were asked to identify their professional degrees and state licensure along with any previous experience. Eleven of the clinicians had obtained a masters degree, with four receiving Massachusetts state licensure in the field of social work. The majority of the clinicians had over five years of experience delivering home-based family therapy services. When examining the previous literature that addressed mandated qualification, strict guidelines were included for clinicians. According to the Massachusetts Division of Professional Licensure (2007) to practice home-based family therapy a clinician must 1) obtain a passing score on the national licensing examination, 2) obtain a master's or doctoral degree in marriage and family therapy and 3) complete two years of full time work experience. That said, the majority of the clinicians (n=10) worked with families by pairing a licensed professional (LICSW) with a masters or bachelors level clinician, therefore meeting requirements to practice in Massachusetts.

Participants were also asked to describe any specialized home-based or family training they had received. Other than coursework, only a small number of clinicians had taken part in any continuing education training. This continuing education included:

hospital crisis prevention, reactive attachment disorder, adoption, Minuchin family systems therapy, and brief strategic therapy. Although specialized training was somewhat limited among the clinicians, Berg and Kelly (2000) found that traditional classroom work was beneficial to the training of home-based therapists, therefore validating many of the experiences of clinicians in this sample. Along with class work, Berg and Kelly (2000) found that on-site training, case consultations, peer support, and supervision were essential learning tools for home-based therapists.

Family Systems

As a result of his work with families and family systems, Minuchin (1974) developed structural family therapy. Minuchin found that structure, subsystems, and boundaries were all essential components to his theoretical formulation. Similarly, when asked to describe a well functioning family system, clinicians in this study overwhelmingly found that boundaries and structure were important aspects to family functioning. Minuchin's third component, subsystems, which Nichols (2006) defined as follows, "Families are differentiated into subsystems based on generation, gender, and common interests" (p.174) was not mentioned by the clinicians. Instead many home-based therapists stressed the importance of communication between family members. One clinician stated, "I think one of the biggest things for a well functioning family system is they have elements of positive communication and positive understanding of the other family members." For the clinicians, communication was a way for the family to remain connected and involved in each others lives, therefore leading to less dysfunction and instability. Flouri and Buchanan (2002), whose study looked at parental

involvement and the rate of suicide among adolescents, reported similar findings. Flouri and Buchanan stated, “This study showed that adolescents who reported higher parental involvement were less likely to have made suicide attempts...that apart from parental emotional support, parental responsibility, engagement, and accessibility protected against attempted suicide” (p.21). Nichols (2006) also found that communication could be a great facilitator for change. A therapist using process/content distinction can, according to Nichols, “Learn to attend as much to how families talk as to the content of their discussion” (p. 13). This process allows clinicians to recognize adaptive and maladaptive patterns of communication between family members and change how they communicate creating a stable, more functional home environment.

Similar to the importance of communication, safety, in the home and between individuals, was an aspect of family life that clinicians found critical when describing a family that functions well. The majority of the clinicians defined a safe home as one where there is no abuse between family members. Previous studies referenced safety as being safe from one’s self and not in relation to other household members. Costello et al (1991), Dicker et al (1996), and Hillard et al (1988), all found that suicidal ideation and being a threat to your own person was a reason for hospitalization and the leading criterion for psychiatric hospitalization. Barber et al (1992) found similar results, stating that suicidal ideation and behavior were determinants for being hospitalized for an intermediate amount of time. Katz and Woolley (1975) addressed safety in the context of hospital discharge. By interviewing hospital staff, it was found that individuals who were no longer a threat to self or others were discharged.

Lukens et al (2004) and Grisso et al (2000) investigated the possibility of violence in the home and found that the psychiatric diagnosis of a child can bring up feelings of anger and resentment, both in parents and siblings. When anger and resentment emerge in some or all family members, the potential for violence increases resulting in individuals feeling unsafe in their own home. Grisso et al (2000) found that there is a small likelihood that violent thoughts may continue after discharge. Although Grisso et al noted that more than half of all hospitalized child patients reported that the violent thoughts dissipated. For those individuals whose violent thought continued post-discharge, put other household members at risk.

Cottrell (1994), who researched home-based therapists and the advantages and disadvantages of in home work, noted that there are potential safety risks for home-based therapists. Cottrell wrote, "Is it safe to visit families alone? – often the answer is no" (p. 194). Many clinicians opt out of home-based work for this very reason. Personal safety was not a topic of discussion during the interview, and therefore not addressed by the participants.

Kluckhohn and Spiegel (1954) as found in Nichols (2006) examined the roles of family members and noted, "That healthy families contained relatively few and stable roles, and that this pattern was essential to teach children a sense of status and identity" (p.24). Of note, the findings of the current study did not involve roles; that is, these clinicians did not speak of individual roles within the home. Clinicians were not directly asked about roles and the relationship they played within family dynamics. Instead clinicians were asked to describe a well functioning family systems and were not asked

for specifics. By not asking specifics clinicians were not pressured to speak about topics they did not feel impacted family functioning, including roles.

Agency Protocol and Disposition

In their quest to assess the needs of a family, all the clinicians stated that they used a standardized protocol. This assessment form, created by each agency, asked questions regarding household members, current and previous services, strengths, family history, and current needs. This assessment is completed within the first few sessions when meeting with the family. Similarly, The National Youth Network (2007) agreed that assessment of individual and family needs is essential, “Outpatient therapy is beneficial in providing initial assessment regarding the need for psychiatric counseling, as well as offering follow up support to individuals” (pg. 1).

Despite assessing the needs of each client, half of all clinicians reported that determinants for services did not come from the agency, instead the extent and type of service delivery comes from the Department of Social Service or the family’s insurance company. Occasionally, families were able to self- refer to the home-based agency and therefore, could determine what services they would like. One clinician felt it was important to view the family as the expert during both assessment and the determination of services. Nichols (2006) echoed this idea of having the family as the expert, “The therapist doesn’t solve problems; that’s the family’s job” (p.181).

Case Example

All clinicians in the sample were asked to present a case that involved a psychiatrically hospitalized child and their family. The age of the hospitalized clients

ranged from seven to thirteen, which is similar to Hillard et al (1988) who found that, “Age (younger children are hospitalized more frequently)” was a major factor in reason for hospitalization. Although younger children are hospitalized more frequently according to Hillard et al, there was little written on the child’s experience during hospitalization. Most of the previous research focused on adolescents (Dicker et al, 1996; Hillard et al 1988; Mason and Gibbs 1992).

The reasons for hospitalization, participants reported, were overwhelmingly similar despite each case involving a different family. Eleven clinicians reported that aggressive behavior was the major reason the child was hospitalized. The twelfth clinician stated that her client was depressed and exhibited cutting behaviors. This child was subsequently hospitalized for her deteriorating mood. Hospitalization for aggressive behaviors differed from both Dicker et al (1996) and Hillard et al (1988). Hillard et al found, “The presence of suicidal tendencies was the strongest predictor of adolescent admissions” (pg. 1418). Similarly Dicker et al (1996) concluded, “The presence of depression emerged as the most important predictor of hospitalization” (pg. 769). The twelfth child who was hospitalized was similar to Dicker et al given her increasingly depressed mood. Yet the difference in the previous literature and this study’s current findings are quite substantial. These differences could be attributed to several factors. Clinicians were not specifically asked if aggressive behavior included suicidal tendencies, ideations, or depression. Difference could also be attributed to population, location, and individuals within the hospital admitting the child.

The American Academy of Child and Adolescent Psychiatry (AACAP) (1989) created guidelines for the hospitalization of children. The AACAP clearly states that a

child can only be hospitalized when there is a presence of a psychiatric disorder. According to the DSM-IV-TR (2000) these disorders include: mental retardation, learning disorders, motor skill disorders, communication disorders, pervasive developmental disorders, attention-deficit and disruptive behavior disorders, tic disorders, and elimination disorders. Barber et al (1992) also state that children can be diagnosed with: affective, anxiety, personality, and adjustment disorders. Substance abuse, schizophrenia, and personality disorders are also found in children. For half of the clinicians they reported that diagnosis came after the child was hospitalized. The AACAP also states within its guidelines that only a licensed child psychiatrist can determine if a child should be hospitalized. Within their narratives clinicians stated parents, DSS, or themselves made the decision to have the child screened at the hospital. Since the children were under the age of 18, the parents served as the major decision maker.. For many of the parents, the screening and evaluation for psychiatric hospitalization was done on a voluntary basis and they went with the child to the hospital. Other parents reluctantly had their child screened upon the strong recommendation from DSS. For one parent, the fear of losing her child due to noncompliance of a court order allowed the DSS worker to have her child screened and admitted.

It was not clear who admitted the child upon arrival at the hospital. Clinicians did not mention who made the decision to admit. But according to the AACAP (1989) a child psychiatrist or a licensed psychiatrist with specialized training would have had to screen the child themselves or at least make the final determination of admittance.

The clinicians in the sample reported that hospitalization lasted one week to sixty days. Clinicians stated that length of time varied for a number of reasons that included:

waiting for a bed to open up in another facility, parents not wanting the child to return home, diagnostic assessment, and medication management were all factors in the length of time the child remained in the hospital. Barber et al (1992) explored determinates for optimal length of stay in a hospital setting and presented more specific criteria than those described by the sample clinicians. According to Barber et al (1992), shorter stays involved diagnoses such as adjustment disorder, intermediate stays involved affective disorders, and a diagnosis of schizophrenia was considered appropriate for a longer stay. Clinicians reported that half of all the children were hospitalized before receiving a formal psychiatric diagnosis. Their hospitalization was the result of the aggressive behavior, therefore the findings of the current study were unlike Barber et al's given that children were hospitalized for reasons not based on diagnosis. Once hospitalized, a number of the children in this study were diagnosed with bi-polar disorder, yet their stay ranged from only a few days to several months and not for an intermediate amount of time, such as what Barber et al (1992) found. No children were diagnosed with schizophrenia yet a few children were inpatient for a longer period of time. Their longer stay could be attributed to other factors. A few clinicians reported that children remained in the hospital until the home-situation improved or therapeutic services were in place, such as a day program. One clinician stated that the parents did not want their child to be discharged until stable housing was found. Most of the children who were hospitalized for aggressive behavior, which Barber et al would consider appropriate for only a short stay, again varied from one week to three months.

Family Functioning

During the child's hospitalization, participants reported that many parents felt a sense of relief, both in stress and worry. Also some clinicians reported that many parents experienced a sense of guilt. One clinician stated, "A lot of time a family has guilt. Guilt over did I do this to my child... But all you can say is that they are not responsible for that, it is a mental illness and you can't control it." Also parents experienced guilt around feeling relieved their child is out of the home and that there is less stress. These findings are similar to Marsh (1998) who found that parents experience some guilt when their child is diagnosed with a mental illness stating, "They [parents] seemed to be trying to find out how we caused it. It was just devastating." (p. 232). The sample clinicians also reported that there is sadness in parents over the hospitalization of their children. One clinician stated, "But it also felt like there was somewhat of a funeral feeling... I know that Mom and the little girl were acutely afraid that they were going to lose her." Similarly March and Johnson (1997) found that parents can experience grief over their child's diagnosis stating, "When a child develops a mental illness, his or her parents generally experience a range of intense losses, both real and symbolic" (p. 232).

Participants were also asked to describe the family's experience once the child was discharged from the hospital. The majority of clinicians reported that overall family functioning was better, with less fighting, and more appropriate behavior. Even though many clinicians reported that family function improved, some observed that home lives become more chaotic and the parents become anxious over their child's return. Thus, the particular parents and siblings described in this study were involved in the lives of the

hospitalized child. Flouri and Buchanan (2002) found a dissimilar result; parents in their study were uninvolved resulting in higher suicide rates and hospitalizations.

In a number of the families, siblings played a role in the family dynamics during and after hospitalization. For those families who had more than one child, the clinicians reported that the siblings experienced parents who were preoccupied in caring for the hospitalized child. Many siblings then acted out or were hurt emotionally by the lack of attention from their parents. March and Johnson (1997) found similar responses in siblings, writing, “Siblings may experience the dual losses of their brother and sister and of their parents, whose energy may be consumed by the mental illness” (p. 232). Lukens et al (2004) who interviewed older children regarding a sibling’s mental illness found a different, perhaps more mature outlook due to the age of the older sibling. Lukens et al noted that siblings expressed an array of emotions including, loss, guilt, fear, and anger.

Interventions

To help families stabilize after the hospitalization of their child, clinicians used a number of intervention techniques. The majority of the clinicians stated that psychoeducation was helpful in easing parent’s fears about their child’s diagnosis and future. Many parents experienced guilt thinking they had somehow been responsible for their child’s mental illness. Thus, these clinicians educated parents about mental illness and its source. These home-based therapists also taught coping skills to parents, siblings, and the hospitalized child during and after discharge. During the hospitalization clinicians helped parents develop ways to care for themselves both mentally and psychically. After hospitalization, hoping to divert crisis, clinicians stated that they wanted to give families

the ability to deescalate their own conflict and avoid hospitalization again. Along these lines, participants reported that they developed a contract for safety between parent and child, so if a situation did escalate they know what steps to take in order to remain safe.

Minuchin's (1974) structural family therapy included interventions that would help therapists change the dynamics of families in a more positive way. The overall goal in structural family therapy is similar to the goals of the sample clinicians in terms of overall purpose, but the techniques are somewhat different. Specifically, Minuchin's interventions involved the clinicians reworking the family structure and creating well-defined boundaries and subsystems. The clinicians in this study helped families to move through this crisis and develop techniques to avoid repeating similar patterns.

Stabilization

The majority of the home-based therapists reported that after hospitalization, families did stabilize. These clinicians stated that some families stabilized "almost immediately," while others stabilized within six months. The previous research (Grisso et al, 2000; Nolan, 1997) both contradicted and supported these findings.

Grisso et al (2000) found that many individuals were unable to make the transition back into society and were re-hospitalized soon after discharge. Nolan (1997) found similar results stating that within a year nearly a third of the individuals she followed were re-hospitalized (pg. 81). Some findings in both the Grisso and Nolan studies contradicted the responses of some clinicians in the sample. Both Grisso and Nolan stated that stabilization is not always possible and many individuals eventually returned to the hospital, while participants in this study found that the majority of the

families did stabilize and the child did not return to the hospital. In support of the participants responses, Grisso et al (2000) also found that individuals who had violent thoughts during hospitalization more than half reported that they had subsided after discharge. When the patient's violent thoughts subside, there is a possibility of stabilization within the home increases. The household remains safer and people are able to relax and communicate with one another. Grisso et al's findings' regarding the reduction in violent thoughts supports the participant's reports that stabilization can occur.

Termination

Overall, the participants reported that termination occurred when to the initial goals of the referral were met. Some clinicians were unable to terminate for a variety of reasons including: children who did not return home, case had not yet closed, or closed early due to DSS of the family's insurance. However, those clinicians who were able to terminate felt it was at the right time and the family and themselves were ready to close.

Minuchin (1974) believed that when a family in crisis was able to work with the therapist and change the structure creating more solid boundaries and subsystems, the treatment was completed. This parameter was similar to most clinicians' termination experience in this study. When clinicians were able to move the family through crisis and give them the tools necessary to avoid the next crisis, then treatment was completed and termination occurred. Both Minuchin (1974) and most sample clinicians worked similarly, that is if the initial goals were met the case was closed.

Clinicians were also asked to describe the families and their reaction to termination. The majority of the families were ready to close, understanding that their goals had been met, experiencing that their family was again stable. Some families found it difficult to let go, as the clinicians were closely involved in their lives for several months. Cottrell (1994) reported a similar finding about the relationship between family and therapist stating, “The family’s knowledge that the therapist understands their plight may increase engagement” (pg. 92). Because families can become engaged with the therapist and there are a number of emotions surrounding the relationship termination can be difficult.

There were no previous studies that explored how the home-based clinician experienced termination. A number of clinicians were pleased with the termination process and felt that they had helped the family in some way. Others described the termination as going very poorly with one clinician stating, “It was probably one of the worst terminations I have ever done.” The majority of the clinicians in this sample felt that most cases involving hospitalized children were “messy” and difficult. Clinicians reported that their cases involved a lot of work and required a great deal of travel from home to hospital. One clinician described her feelings about the case stating, “My honest reaction was [that] I was just exhausted by the case.” A number of the clinicians reported similar reactions, with exhaustion in their voice and expression, stating that they were pleased that the case was closing.

Implications for Social Work Practice

Home-based clinicians provided, through their narratives, cases of hospitalized children. These home-based therapists spoke of the family's reaction during and after hospitalization and their intervention to attempt to re-stabilize the family. Although the sample itself was small, the ideas generated from the clinicians were valuable in that they could be applied and used by other clinicians working with a family experiencing a similar situation. Participants reported that during hospitalization both parents and siblings experienced a wide range of emotional reactions. Parents reported that they were at times relieved their child was out of the home, but many times that relief was accompanied with guilt or sadness. Siblings found parents preoccupied and distracted causing them to act out more. Home-based clinicians who have yet to experience a case where a child in the family is psychiatrically hospitalized, could prepare themselves for how the family might react. Rather than walk blindly into the situation clinicians could have some understanding of what to expect when one of the children becomes hospitalized.

All home-based therapists should be engaged in supervision, peer consultation, and case discussion with those who have more experience in the area of home-based clinical services and childhood psychiatric hospitalization. Supervision, peer support, and case consultation were ways in which each clinician in the sample received help on their cases. The clinicians were able to develop and implement alternative interventions and gained the much needed support and confidence to work with a family who was experiencing a very traumatic event. Utilizing their colleagues and supervisors as a

resource helped all home-based clinicians in the sample better serve the needs of a family and themselves.

Clinicians helped these families cope with their emotional responses to their child's psychiatric hospitalization and later discharge by providing an array of interventions. Psychoeducation was provided about mental illness as many parents expressed their concern about having caused their child's illness. Clinicians also assisted by working with parents to develop and improve coping skills and attention to self care. Many parents over extended themselves by commuting back and forth to the hospital; as this put a strain both on themselves and the other children in the home. Clinicians encouraged parents to take time for themselves and attend to the other children in the home. Thus, home-based clinicians implemented effective and relevant strategies to aid the family when they become overwhelmed. Through the use of psychoeducation, coping skills, and self care, clinicians provided their families with immediate relief by using proven interventions rather than trial an error that resulted in the families quicker return to stabilization.

As reported by participants, aggressive behavior was by far the leading cause of hospitalization for the majority of the clinicians in this study. Behaviors such as punching, kicking, screaming, throwing objects, and fighting with siblings were all observed behaviors that preceded the hospitalization. If home-based clinicians were aware that these behaviors may result in the child becoming hospitalized, their interventions then could be more focused and direct. With their choice of intervention, hospitalization could possibly be avoided saving the family a great deal of pain and chaos.

Recommendations for Future Research

This section discusses recommendations for further research in the field of social work, particularly with regard to home-based therapy. This section also covers the limitations and biases in the literature and this study. This section is divided into the following sub-sections: 1) limitations and biases, and 2) future research.

Limitations and Biases

There were a number of limitations presented both in the data and literature. Within the literature the most prominent limitation is the focus of research, which tends to examine the adolescent and adult psychiatric hospitalization. It should be noted, here, that Hillard et al (1988) wrote, “Younger children are hospitalized more frequently” which makes one question why the focus in most previous studies had to do with adolescents. Similarly the literature rarely focused on home-based therapy. Instead, most studies examined therapy with these families within a clinic or agency setting. Therefore, home-based therapists are underrepresented within the literature and the outcomes of this treatment modality remains unexamined. This gap in the research leaves room for over generalizations regarding outpatient working being similar to home-based therapy and ideas and practices being similar in each field.

Like the literature there were a number of limitations within the study itself. Perhaps the most prominent limitation was the small sample size. Twelve clinicians participated in this study, representing only a small fraction of the thousands of home-based therapists. Similarly, all participants resided and practiced in Massachusetts and followed state guidelines regarding family therapy and hospitalization. Clients were also

hospitalized in Massachusetts, many in some of the same hospitals. If given a larger sample size and more diverse group of clinicians in terms of geographic location, the findings of this study might have been more generalizable.

Another limitation of this study was the lack of diversity among the participants. Participants consisted of eleven women and one man, all self identified as Caucasian. There was little diversity among participants in terms of race and language, but many of the clinicians were from various ethnic backgrounds. Diversity among the participants was a high priority during recruitment, but of those that responded to participate these twelve met all requirements and had ideal case vignettes to share. If greater diversity was present among participant's findings could have been more generalizable to other races and cultures.

There were a number of areas addressed in the literature that were not addressed by the participants. This omission might have been due to clinicians not addressing these areas because they thought it is not part of their job. The clinicians were not asked specifically about these areas by the researcher. The areas of inquiry not addressed by clinicians included: individual roles within the home, hospital admittance, personal safety, and specifics around timing of diagnosis. If these areas of inquiry were incorporated into the interview guide more substantive information about the similarities or difference between the literature and the findings would have emerged.

Future Research

Home-based therapy is an underrepresented in terms of the previous literature. Any research focusing on home-based services would be both beneficial to those

clinicians who work within the home and in the field of social work in general. Future research might include a large sample size that crosses state and international borders. Studies should include clinicians from different cultures as well as cases that involve families from different ethnicities and race.

The focus of this study was solely on the families' experience of a first hospitalization. Future research might examine the family's reaction to numerous psychiatric hospitalizations and how those family dynamics are affected. Similarly this study was intended to examine a parent's response to their child's hospitalization; siblings, as part of the family unit, were mentioned yet not explored in depth. Researchers might conduct studies that examine in more depth the reaction of siblings to a hospitalization. Finally, clinicians worked with families in a time frame of three months to one year, if the opportunity presented a long term study to examine the changes in family dynamics over time would be both interesting and educational.

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Appendix A

Informational Letter to Clinicians

To Whom It May Concern:

My name is Ashley Logee. I am conducting a study about family systems to learn more about how home-based clinicians deal with changes in family dynamics after the psychiatric hospitalization of a child. The study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College School for Social Work.

I have contacted your agency after an extensive search resulting in only a few agencies that are found to provide home-based family therapy. I am currently looking for home-based clinicians who are willing to share their experiences and become participants in my study.

As a participant, home-based therapists will take part in a 45 to 60 interview where they will be asked questions that will focus on what changes in family dynamics they have experienced/witnessed after the discharge of a child from a psychiatric hospital. Questions will also focus on what goals and interventions were to helpful in transitioning the child back into the home and to return the family to a state of pre hospitalization.

It is my hope that this study will help social workers have a better understanding of what to expect when a child has been hospitalized and returns home. Also I hope to provide clinicians with potential interventions that could benefit the family and therapeutic process. Finally it is my intent with this study to increase awareness of home-based therapy among other professionals in the field.

If there are home-based clinicians in your agency who are interested in becoming participants of this study they can contact me by email at alogee@email.smith.edu.

Sincerely,

Ashley Logee
Master of Social Work Intern

Appendix B

Human Subjects Approval Letter

November 27, 2007

Ashley Logee

Dear Ashley,

Your revised materials have been reviewed and you have done a fine job with their amendment. All is now in order and we are happy to give final approval to your study.

In going over the material again, I did have one thought. You are requiring that your participants have five years of experience doing home based work. Getting enough participants is always the most difficult part of a thesis and I worried that this requirement might unnecessarily limit your pool. Do you think they could be a useful contributor if they only had two years? Finding folks who have done home based work following the psychiatric hospitalization of a child may be tough enough. I don't know. Think about it.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain signed consent documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor

Appendix C

Informed Consent Form

My name is Ashley Logee. I am conducting a study about family systems to learn more about how home based clinicians deal with changes in family dynamics after the psychiatric hospitalization of a child. The study is being conducted in partial fulfillment of the requirements for the Master of Social Work degree at Smith College School for Social Work.

I am interested in how home based clinicians deal with changes in family dynamics post discharge of a psychiatrically hospitalized child. You are being asked to participate in this study if (a) you are a licensed home based clinician, and (b) you have been practicing for more than five years and have had experience with psychiatric hospitalization and families. As a subject in this study you will be asked to participate in a face to face interview. Questions will focus on what changes in family dynamics you have experienced/witnessed after the discharge of a child from a psychiatric hospital. Questions will also focus on what your goals and interventions were to help transition the child back into the home and to return the family to a state of pre hospitalization. The interview will take between 45 to 60 minutes. Interviews will be tape recorded with your consent, and tapes will be coded numerically to ensure your confidentiality. Tapes will be destroyed after the interviews have been transcribed.

Your participation is voluntary. You will receive no financial benefit for your participation in this study. However, you may benefit from knowing that you have contributed to the knowledge of family systems and how psychiatric hospitalization of a child impacts a family. It is my hope that this study will help social workers have a better understanding of what to expect when a child has been hospitalized and returns home. Also I hope to provide clinicians with potential interventions that could benefit the family and therapeutic process. You may also benefit from being able to tell your story and having your perspective heard.

The potential risks of participating in this study are none to minimal as you are a professional in the field of mental health. There may be the slight possibility that you may experience strong or uncomfortable emotions while talking about your experiences.

Strict confidentiality will be maintained, as consistent with Federal regulations and the mandates of the social work profession. Confidentiality will be protected by coding the information and storing the data in a locked file for a minimum of 3 years. Your identity will be protected, as names will be changed in the analysis of the data. Your name will never be associated with the information you provide in the questionnaire or the interview. The data may be used in other education activities as well as in the preparation for my Master's thesis.

This study is completely voluntary. You are free to refuse to answer specific questions and to withdraw from the study at any time. You may decide to withdraw at any time until March 1st when the final report will be written. If you choose to withdraw from the study, all data describing you will be immediately destroyed at that time.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR

**PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE
IN THE STUDY.**

SIGNATURE OF PARTICIPANT

SIGNATURE OF RESEARCHER

DATE

DATE

If you have any questions or wish to withdraw your consent, please contact:

Ashley Logee

alogee@email.smith.edu

Appendix D

Interview Guide

1. Can you provide the following demographic information?
 - A. age
 - B. gender
 - C. race
 - D. ethnicity
 - E. degree obtained
 - F. specialized training in family systems or home-based therapy
 - G. number of years in the field
 - H. average case load
 - I. number of cases with psychiatrically hospitalized children
2. How would you describe a well functioning family system?
3. Describe a family that functions well?
4. Please describe your agency's protocol for conducting family assessments.
5. Please describe the criteria used for determining the type of service delivery.
6. Please describe one case example (disguised, of course) where you worked with a family pre, during, and post hospitalization.
7. What changes in family functioning did you observe during the hospitalization period and after the child returned home?
8. What specific interventions did you provide and how did it impact the family?
9. Did the family stabilize?
10. Over what time period did the family stabilize?
11. Describe the termination process.
12. What was the family's reaction?
13. Clinician reaction?
14. How did termination occur? Formal? Drop out?