
9-1-2001

"She Even Walked the Dog": The Roles of Relational Context and Goal-Setting in a Welfare to Work Program

Lynne A. Kellner

Fitchburg State College, lkellner@fsc.edu

David Haddad

Fitchburg State College, dhaddad@net1plus.com

Ann G. Forcier

Fitchsburg State College

Follow this and additional works at: <https://nsuworks.nova.edu/tqr>



Part of the [Quantitative, Qualitative, Comparative, and Historical Methodologies Commons](#), and the [Social Statistics Commons](#)

Recommended APA Citation

Kellner, L. A., Haddad, D., & Forcier, A. G. (2001). "She Even Walked the Dog": The Roles of Relational Context and Goal-Setting in a Welfare to Work Program. *The Qualitative Report*, 6(3), 1-32. <https://doi.org/10.46743/2160-3715/2001.1998>

This Article is brought to you for free and open access by the The Qualitative Report at NSUWorks. It has been accepted for inclusion in The Qualitative Report by an authorized administrator of NSUWorks. For more information, please contact nsuworks@nova.edu.



Qualitative Research Graduate Certificate
Indulge in Culture
Exclusively Online • 18 Credits
LEARN MORE

NSU
NOVA SOUTHEASTERN
UNIVERSITY

NOVA SOUTHEASTERN

"She Even Walked the Dog": The Roles of Relational Context and Goal-Setting in a Welfare to Work Program

Abstract

This report summarizes an evaluation of the effectiveness of a welfare-to-work program that is operated by the Montachusett Opportunity Council (MOC) in Central Massachusetts. The study looks at how effective the program was in helping clients achieve goals towards self-sufficiency and tries to understand the particulars of the trusting relationships between staff and clients that provided the base from which they worked to address multiple concerns impeding family financial self-sufficiency.

Keywords

qualitative research

Creative Commons License



This work is licensed under a [Creative Commons Attribution-Noncommercial-Share Alike 4.0 License](https://creativecommons.org/licenses/by-nc-sa/4.0/).

Acknowledgements

This project is a product of the Community Partnership Outreach Center at Fitchburg State College, which was funded through a grant from the Department of Housing and Urban Development.

"She Even Walked the Dog": The Roles of Relational Context and Goal-Setting in a Welfare to Work Program

**by
Lynne A. Kellner and David Haddad
with Ann G. Forcier[±]**

The Qualitative Report, Volume 6, Number 3 September, 2001

Abstract

This report summarizes an evaluation of the effectiveness of a welfare-to-work program that is operated by the Montachusett Opportunity Council (MOC) in Central Massachusetts. The study looks at how effective the program was in helping clients achieve goals towards self-sufficiency and tries to understand the particulars of the trusting relationships between staff and clients that provided the base from which they worked to address multiple concerns impeding family financial self-sufficiency.

Introduction

Fitchburg is an old mill town in Central Massachusetts with a population of approximately 41,000. As manufacturing jobs left the area, unemployment and crime increased. Fitchburg historically has served as an entry point for many minorities; 20% of the total population is composed of minorities: Hispanics, African-Americans, and Asians. "According to the Massachusetts Department of Revenue in 1996, of the 351 cities and towns in the state, Fitchburg was ranked 338th in per capita income" (Fitchburg State College, [1997](#), p. 2.1). In the areas targeted for the Families First project, more than 41% of residents were in the low-to-moderate income range and 25% lived in poverty, almost three times the then state average (FSC, [1997](#), p. 2.1). According to the 1990 Census, the median household income for the state was \$36,952 while in the city of Fitchburg it remained at \$27,101. In the neighborhoods targeted for the Families First program, the median household income ranged from \$15,952 to \$17,744 (FSC, [1997](#), p. 2).

The Personal Responsibility Act of 1996 eliminates the entitlement status of welfare and created block grants called Temporary Assistance for Needy Families (TANF). TANF replaces AFDC (Aid to Families with Dependent Children). Spending is capped, and states receive a lump sum rather than open-ended entitlement funds. The end of open-ended funding means that welfare spending will be reduced. As in other assistance programs that help many eligible families, TANF will need to efficiently move people from welfare to work. This report is a study of the Families First program run by the Montachusett Opportunity Council (MOC) in Fitchburg, MA, and sought to:

- define "success" as understood by clients and staff.
- determine the effectiveness of the Families First program in helping clients achieve their goals.
- determine whether staff and clients identify the same or different elements as helpful in a client's struggle for self-sufficiency.
- create a tool for staff to use to monitor the progress of the program.
- use the information gathered from interviews of staff, clients and administrators to create a training manual for future staff.

Because of the institution of Welfare Reform, MOC staff recognized that many clients would face the need to move from depending on financial assistance to financial self-sufficiency. Self-sufficiency is a term that includes more variables than the federally established poverty limits. The poverty line is set at three times the amount of money a family is expected to need for food (Schram & Mandell, 1997, p. 232). The Self-Sufficiency Standard (Pearce, Russell, & Brooks, 1998, p. 6) calculates how much money a working adult needs to meet the family's basic needs for housing, child care, food, transportation, health care and taxes.

Self-sufficiency does not imply that families should be completely self-reliant and independent. Indeed, it is through interdependence among families and community institutions such as schools and churches, as well as informal networks of friends, family, and neighbors, that many families are able to meet their non-economic needs as well as economic necessities.

While the poverty line does not include income adjustments made on the basis of children's ages or where a family lives, the self-sufficiency index established in Massachusetts does. Compare the figures below (see [Table 1](#)).

**Table 1: Comparative Economic Indicators
Single-Parent with one preschooler and & school-aged child (Worcester County)**

| Poverty Line | Income: Welfare & Food Stamps | Self-Sufficiency Index |
|--------------|-------------------------------|------------------------|
| \$13,300 | \$10,272 | \$35,460 |

The poverty line is a mere 38 percent of what this family needs.

Although an evaluation of the Families First program was mandated by the United States Department of Housing and Urban Development (HUD) because MOC received federal funds, MOC staff welcomed the opportunity to better articulate how they actually worked with clients. When we were first enlisted as researchers of the Families First program, the Program Director explained that staff had been too busy actually working to sit down either to develop a program manual or formalize their work. He stated that clients were very involved and made steady progress towards self-sufficiency.

History of Program

The Families First program, as conceived in May 1996, aimed to aid local families who were willing to be "working partners" with MOC staff to establish financial independence and self-sufficiency. The program philosophy is rooted in the belief that families will move toward self-sufficiency when they feel empowered to do so themselves. The role of staff is to give adequate information that highlights potential benefits and consequences of various choices so that families can make informed decisions. The Families First program is housed at the Community Action Center in Fitchburg; however, services are provided both in the community and in the office.

Methodology

This study had two steps: to learn what services were seen by the staff and clients as effective and to understand what it was about the service that made it effective. As conceptualized by staff, services were to

- assist in identification of family strengths and support systems.
- assist in assessing needs and in identifying family and community resources to address those needs.
- provide information, referral, advocacy and coordination of services.
- assist in the development of "Families First Plan of Success", which establishes goals, determines immediate and future service needs, and outlines action steps for attaining short- and long-range goals.
- support families in problem solving.
- provide monitoring and follow-up to facilitate progress towards goals.

From this list of program goals, we developed our research goals by comparing and contrasting the perceptions of clients, administrators and staff. We wondered about their perceptions of "success" and how these perceptions compared with "hard data". Did clients meet their goals as determined by measurable standards and if so, how could this information be used to help track client progress and train future staff?

Because we sought to understand and document the subjective experiences of those involved, we chose interviewing as the focal methodology. We assume that the meaning people make of their experience affects the way that they conduct that experience (Seidman, [1991](#)). Through language, as Anderson and Goolishian ([1988](#)) suggest, meaning is generated and personal or interpersonal change takes place.

Both authors had prior clinical experience with MOC's Head Start program as well as a research interest in how the perception of services affects the collaboration between client and provider. One of the authors (LK) is on the behavioral sciences faculty of Fitchburg State College, a school with a long tradition of providing evaluation for state and federally funded area programs. As a result, when the Families First Program evaluation was posted in the college's grants office, the authors felt the combination of their prior experience and research interest was a good fit.

We met the Families First staff on several occasions to learn about the program and to discuss the purpose of the research. During the first meeting, the three case managers and the program

manager shared their ideas about why the program was so successful. They agreed to continue this discussion in individual audiotaped interviews over the next few weeks.

After we were comfortable that they understood the purpose of the study, staff discussed it with clients. Program staff received a written description and informed consent form ([Appendix D](#)) to give to prospective client-participants. If clients agreed to participate in the study, researchers met them in their homes or in the Community Action Office where the program was housed

Because the researchers were interested in how the perceptions of clients compared with those of staff, a semi-structured interview for clients was developed using the themes generated from the staff interviews (see [Appendix A](#)). This type of questioning provided direction yet was flexible enough to allow researchers to explore issues as they emerged. We paraphrased information and fed back our understandings to client-participants for their comments and clarifications (Heron, [1981](#)). We maintained considerable flexibility about who asked which questions; however as the study progressed, David focused more on how clients' experiences compared with those they had with previous service providers, and Lynne typically focused on the goal-setting process. This was not pre-determined, but emerged as we worked together.

An evaluation based on qualitative methodologies is well suited to understanding process. Gilgun, Daly and Handel ([1992](#)) observed that "qualitative methods are suited to understanding the meanings, interpretations, and participative experiences of family members" (p. 3). This model allows information to "fold in" on itself repeatedly, thus allowing for validation and clarification. Although originally written for family therapists, the work of Keeney and Sprenkle ([1985](#)) provided a metaphor of dancing to describe the process that we incorporated into our concept of how we interacted with the participants. The process is viewed as consisting of "artifacts of an interactional pattern. The emphasis upon the pattern or dance rather than the dancers leads one to realize that both therapist and client are parts that constitute the whole of an ever-changing and evolving relationship context" (p. 15)"

Additionally, six clients provided written evaluations of the program (see [Appendix B](#)). These written surveys provided a cross-reference that allowed us to determine if clients would respond similarly when granted more privacy. Staff records of client progress were reviewed to assess how clients defined goals and whether they were attained. Staff reported that the criteria for determining whether or not a goal was reached was made by mutual agreement between staff and clients.

After all interviews were complete, we analyzed the data using principles of content analysis (Lincoln & Guba, [1985](#); Miles & Huberman, [1984](#); Patton, [1989](#)). We each created a set of coding categories after rereading all the transcripts. We then reviewed these categories and, though finding considerable agreement, agreed to collapse three categories (practical knowledge, scope of role and perceptions of staff) describing staff characteristics into a global one (staff characteristics). A total of eight self-explanatory topics were chosen. After this final coding, an independent reviewer checked the raw data for its appropriateness within the various categories and decided whether information was excluded or too liberally included. No information was excluded from categories, but four additional entries were made as a result of this inquiry audit. The reader is referred to [Appendix C](#) for full details on methodology.

By collecting data from different sources (clients, staff and administrators) and by utilizing different modes of data collection (oral and written), we created a cross-reference through which to identify inconsistencies and to return to participants for further clarification. This technique, known as triangulation (Lincoln & Guba, [1985](#)), was used to help establish credibility of the interviews.

The Sample

The process of selecting participants began with the professional staff. The direct-care staff consists of three women: one Hispanic, one African-American, and one Caucasian. The receptionist who is clearly an equal player in the program is also Caucasian and a former program recipient. The full-time volunteer is Caucasian, eighty and the mother and head of household of a large family she raised after being widowed and left with seven children at home (see [Table 2](#)).

Table 2: Semi-Structured Interviews

| | Number Interviewed | Individual | Group |
|----------------------|--------------------|------------|-------|
| Client Families | 7 | 5 | 1 |
| Direct Care Staff | 5 | 5 | 1 |
| MOC Administrators | 2 | 1 | 1 |
| Other Administrators | 1 | 1 | 0 |
| Total | 14 | 12 | 3 |

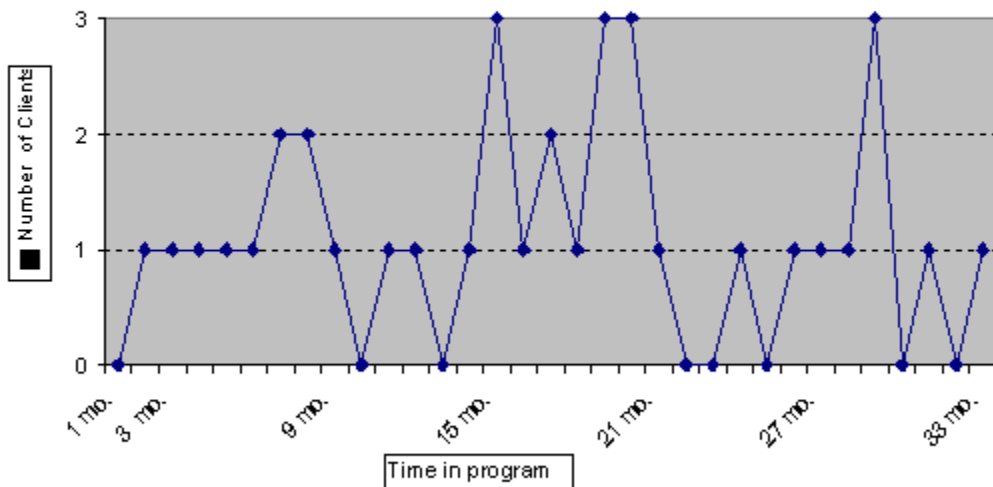
Each staff member was interviewed alone and in a group. Two clients chose to be interviewed together. Researchers were involved in direct interaction and observation for six months. After a draft of this report was prepared, Lynne met with the staff to share impressions and obtain their feedback.

This process created an opportunistic sample (Honigman, [1970](#); Locke, Spirduso, & Silverman, [1987](#)). All participant families in this study were residents of Fitchburg or Leominster, MA. Because the purpose of this study was to generate sufficient descriptions of the Families First program, we determined that opportunistic sampling was appropriate.

By April 1999, nearly three years after initiation of the program, 36 families had entered the program. During the course of this study (January to June 1999), 19 families had open cases. The average length of participation in the program was 16.75 months, with modes of 15, 19, 20 and 29 months. The range spanned from 2 months to 33 months. Despite the apparently lengthy stays in the program, families received services for shorter periods of time than the actual span for which cases were opened and closed. Typically, staff report several failed attempts at making

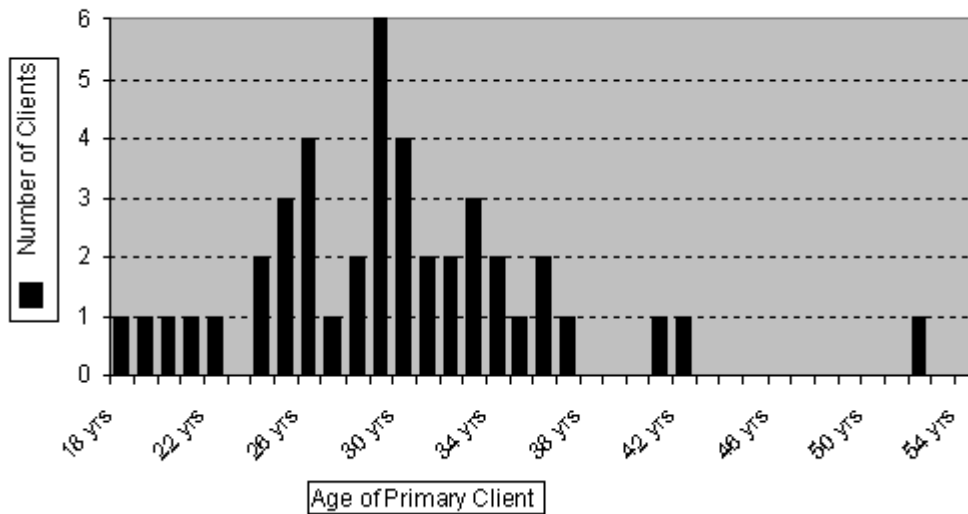
first appointments before actually meeting with prospective participants. The staff practice is to make multiple efforts to contact a family. Though some cases remained open for two years or more, as time passed and families stabilized, the frequency of contact typically decreased from weekly to once a month. The staff reports that families often resist the idea of closing their cases because an open case provides a sense of security; families know they can call if they need to.

Figure 1: Months in Program

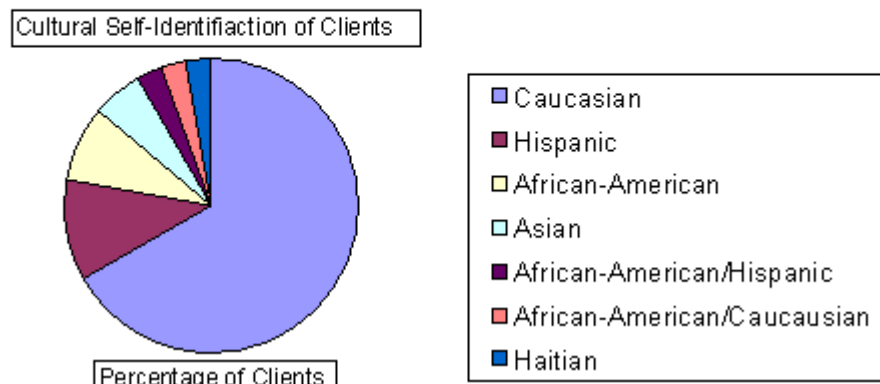


At the time of the clients' intakes, the age of the primary client, usually the mother, ranged from 18 to 51 with a mode of 28. All but one family, in which the children were in protective care outside the home, had children ranging in age from infancy to age 20. The mode was five years. Families had from one to five children with a mode of two. Three participants were pregnant at the start of services.

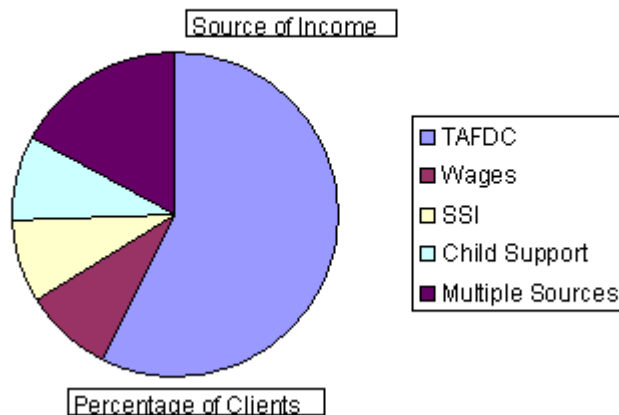
Figure 2: Age of Primary Client at Intake



Thirty (30) families were single-parent families; six families were two-parent families. Twenty-four families were Caucasian; four were Hispanic; three were African-American; two were Asian; one was African-American/Hispanic; one was African-American/Caucasian and one was Haitian. Twenty-four families were referred through other parts of MOC, including Head Start, Daycare, the Learning Center, WHEAT, and the Community Action Center. Families already enrolled in the program referred seven clients. Of the remaining five families, one was referred by staff at an elementary school; one through the Salvation Army; one through Women, Infants and Nutrition (a WIC program); and two from another agency. Twenty families relied on TAFDC, three reported wages, three received SSI, three received child support and six lived on several sources of income.



Figures 3A and 3B: Client Demographics



Limitations of Study

A limitation of this study is the lack of information about families who dropped out of the program or did not accept services. Staff stated that they had difficulty working with clients who were not motivated. Yet clients spoke freely of how the staff helped motivate them. For some, the staff was inspirational; yet we were unable to interview those who staff members were unable to keep involved. Given that we spoke only with those families who engaged in services, or who had previously worked very closely with staff, we find it difficult to evaluate the program's engagement procedure.

Using Multiple Data Points

Given that our study was guided by a naturalistic paradigm, its design emerged as we became more familiar with the program (Lincoln & Guba, 1985) and as the participants, becoming more comfortable with us, allowed us to observe them with decreasing self-consciousness. Our study was guided by data that emerged from four main sources: client records, interviews, client surveys and naturalistic observations.

Since we were interested in understanding the perceptions of clients and staff, and perceptions change over time, it was important to have a way to tease out the more grounded perceptions from possibly more fleeting ones. Therefore, multiple data points were necessary. The semi-structured interviews provided a wealth of material, which we cross-referenced with client responses to satisfaction surveys as well as to tracking of progress (and implicitly satisfaction) as recorded in client records. Acknowledging ourselves as part of the research instrument, we also noted our observations of staff and client interactions during the handful of times we were in the office; this naturalistic observation provided a final cross-reference (Andreozzi, [1985](#)).

Findings

Client Records

To determine the effectiveness of the program, we reviewed client records of all program participants to track the success of the goal-setting process. As part of the Families First program, clients set goals using forms that identify twelve areas of living: housing/shelter, nutrition, health status, alcohol/ drug use, employment, income/budget, adult education and training, children's education, parenting skills, family relations, and transportation. Of the 36 clients in the program, 31 (86%) set goals that were tracked throughout their participation in the program. Four families were not interested in on-going services; two of those were referred to protective services. Families set from one to five goals with a mode of three.

Table 3: Percentage of Families Setting and Attaining

| Goal | Number Set | Number Attained | Percentage |
|-----------------------------|-------------------|------------------------|-------------------|
| Employment | 22 | 16 | 73 |
| Housing | 20 | 13 | 65 |
| Income | 10 | 10 | 100 |
| Adult Education | 10 | 2 | 20 |
| Transportation | 8 | 4 | 50 |
| Money Management | 7 | 2 | 29 |
| Family Relations | 4 | 4 | 100 |
| Child Care | 4 | 4 | 100 |
| Health | 4 | 3 | 75 |
| Children's Education | 3 | 3 | 100 |

The goals became more personalized as the staff and clients used them. For instance, Income and Budget were originally conceptualized as one category; however, as families worked with this goal it became two with remarkably different results. While all ten families who set goals to increase their income achieved this goal, only two of seven families (29%) who chose "money management" as a goal noted improvement. This result suggests a need for skill development in budgeting. Children's Education became subdivided into two categories: child care for preschool children and children's education for older ones.

Twenty-four of the thirty-one families (77%) achieved at least part of their initial goals. While 16 of the 22 clients (73%) setting employment goals reached them, only 2 of 10 clients (20%) achieved goals in adult education. This result leaves open the question of whether adult education goals are long-term ones that take time to track, or whether clients have taken jobs that do not call for additional education. If clients are taking jobs that do not require additional training, it remains to be seen if those positions can provide sufficient income to work toward self-sufficiency.

Some goals are limited by resources. For example, housing changes are contingent upon the availability of affordable housing. Transportation is another long-term goal because most clients setting this goal defined it as acquiring a car. All four families that set goals for improving family relations achieved them. We note this because staff repeatedly said, "We are not counselors." Their clients think otherwise. From these limited results, we believe the staff are good at helping clients to access other resources such as those needed for child care or for their children's education.

All clients identified goals and all had some success in obtaining them. Through client chart reviews, it becomes apparent that our sample was not totally representative, since only 86% of clients set goals and only 77% of clients reached some of their goals. The missing 14% of clients who did not set goals might provide information on difficulties they encountered. However, since we were unable to interview those clients, this information is lost.

Interviews

In the following section, the topics of discussion that emerged from the interviews are categorized into general themes. The following eight general topics of discussion emerged from the 15 interviews:

- Program entry
- First impressions
- Staff characteristics
- Working relationships among staff
- Program philosophy
- How families changed since beginning program
- Experiences with the goal setting process
- Recommendations from staff and clients

Program Entry

Though families came to the program from a variety of entry points, most had some previous relationship with MOC; consequently their entry was easy. The most familiar entry point was the Community Action Center, specifically the food pantry. Most spoke of how easy they found it to begin their involvement with Families First.

Actually, it was a coincidence. I had a friend who was having a real hard time making ends meet, so she heard about the food pantry and the CAC and when things didn't get any better, they invited her into the Families First Program. During her meetings I would come and sit with them.

...I'm new to the program, She (friend) got me introduced to the program.

My sister-in-law was involved in the program and she passed the information on to me. She told me about it and I thought about it for a while and I started thinking it would be helpful.

Well, I was at the CAC, using the food pantry and Wanda (staff) came up to me. I was ready for some kind of program. I had just been through drug rehab and my life was a mess.

For all the families with whom we spoke, some form of crisis brought them in contact with some MOC service, and in this way, defined their readiness for services. Yet, many of these families had been in crisis before and had not accepted services. A central theme that emerged was the perception that Families First staff knew how to handle their crises and made helpful suggestions and referrals.

Given that only families who were adequately engaged in the program were available for interviews, we cannot evaluate what did not "work" for those who did not choose to continue services.

First Impressions

For many, requesting or accepting services is difficult in the best of circumstances. Past involvement with other agencies made some cynical about social services. These preconceived ideas often presented as barriers the staff and client had to overcome. First impressions of the program were diametrically opposed. The majority of clients we spoke with found staff supportive and non-judgmental; but others hesitated to engage because they associated the program with protective services (DSS). One woman who did continue with the program, and later reported significant changes in her life as a result, recalled

When Families First was first described to me, I immediately thought of DSS. I don't know why, I just thought they were going to be too much involved and, I felt like if I were doing something wrong, they would report me.

Other clients reported feeling comfortable from the start.

A friendly safe place, people get along, they want to be helpful.

I was at the CAC and Wanda (staff person) came up to me and told me about the program. My life was a mess and I was ready. Then they came to my house, I couldn't believe that they would come to my house. They would do anything for you, I mean anything.

A family's first impression can set the stage for what follows. Was staff perceived as welcoming and open to their experiences? Have they had negative experiences in the past with service providers? Are their interactions with Families First staff the same or different from previous experiences? What are their expectations of what can be provided? In this study, first impressions were generally positive and clients spoke of how staff members were "different" from welfare workers (seen as condescending) or therapists (seen as more judgmental and having less time). However, we did not have access to those individuals who did not remain in the program.

Staff Characteristics

Clients universally attributed Families First staff with a variety of characteristics that they maintained were central to their success in the program. Staff members were unable to articulate many of their attributes, perhaps out of modesty, while clients had little difficulty listing adjectives to describe the workers. Families easily identified characteristics such as "supportive" or "understanding". Clients described the staff as

Caring, people who just listen. And give emotional support, because sometimes you just have a crazy day. On those days, you need someone who can just be there and listen.

She (Pam) listened. They, she and Wanda (staff) are the most attentive people I've ever met. She listened and he (adolescent son) opened up. There are no accidents. She came into my life for a purpose.

Now Wanda, Wanda is one of the most caring people that I have ever met. She's incredible. She's always there, always listens. She's a godsend. Pam too, she's witty and smart. She'd never judge or make me feel bad. She made charts for the kids to do chores. She and Wanda are some of the most attentive people I ever met.

In times of crisis, they are very supportive. You know, when things are going tough. For instance, they brought me some clothes yesterday, and got me some food, then they got me involved with another program...They're friendly, they don't judge, they just, they are just willing to listen. And they are understanding to what is going on at the time. They don't pass judgments. I could tell them anything and they would be ok with it.

It was often the small things that impressed clients; they were grateful that the staff responded to their needs, no matter what they were. One client recalled how a staff member would walk the dog with her daughter as she collected her thoughts and shifted to a state of mind in which she could make the most of their meetings.

We had a dog at the time. She'd come down and walk the dog with my daughter. She even walked the dog. I know, that's something that she did that!

One mother assessed the competence of a staff member by her ability to engage her angry pubescent son who had rebuffed all previous help. All participants noted that staff goes "above and beyond" what is expected.

Well, they're all caring and outgoing and they go beyond for people. You know, they always call me up, even though I'm not here anymore. I'm learning at a program, it's CPM, but they still call me, find out how things are going, how the kids are doing. I think they are just caring people. They like to be involved, make sure I'm taken care of. Every single one of them.

Staff and families identified certain key characteristics as central to program success. All the families we talked with identified staff as "caring good listeners", while staff identified the need to be "direct" or "persistent". Clients spoke of directness as honesty or authenticity. The persistence staff spoke of was perceived as going "above and beyond" rather than as intrusiveness. One client, on the verge of tears, spoke of how, when she was enrolled in an eight-hour daily training program, the staff would arrange lunchtime meetings at the training site. That the staff would still take so much interest in her touched her. Clients also perceived staff as reliable and trustworthy; although sometimes late for appointments; this was perceived as being "too busy" rather than as a sign of indifference.

Working Relationship Among Staff

Staff attributed much of their success to their ability to work together. When we inquired about how staff worked together, their individual responses identified a respect for each other's differences and strengths. Two staff members recalled their entry onto the staff.

In the beginning I was a little apprehensive, and thinking, how am I going to fit into this group. But I have had no problems. They were willing to work with me when I needed information, help me in any way...

I was scared at first, nervous about joining them. I wondered if I could fit in? Would my skills be challenged? But everyone was warm, and welcoming. I think it was the personalities of the staff.

Staff all agreed that they valued drawing on the expertise of others and expressed a strong commitment to the work they do.

What is important is that we do discuss issues among each other and we try to resolve them for the best interest of the clients.

We work well together because everyone's got a strong personality, which makes it easier to work together with everyone's strengths.

The personalities of the people are a good fit; people are easy to get along with.

This goodness of fit allowed staff to talk freely and openly about goals or differences. Additionally, management supported staff; their immediate supervisor allowed time to "do nothing." She understood that staff were taxed emotionally and needed time to recharge. She helped staff vary their workload so that they could mix in record keeping (which wasn't so emotionally charged) with the direct care responsibilities. The program supervisor commented

I don't care if they're (staff) sitting there having coffee and staring into space when I walk in. I know that they work hard. It's hard work they do. They need time to sit back and relax. I know they're doing their jobs.

Given the success of the program, the working relationship among staff was important to understand. The same behaviors that clients identified as aiding their success in the program, that is, "staff is caring" or "non-judgmental," are the ones that staff most admire in each other.

One client spoke of two staff members as an "old married couple."

It was just like an old married couple. You know, they would come in and sit around the table. You know, Pam would have the folder, and Wanda would ask the questions and Pam would write everything down. And Pam would always have an idea. 'Oh, what about if we did this?' And Wanda would know if they could or they couldn't. It was like they belonged together.

Other clients spoke of staff interacting well and demonstrating respect for one another. Clients commonly perceived staff as "liking" one another, a state that clients felt made it comfortable for them to enter the office for services. Clients contrasted this to other agencies in which they sensed tension among staff. The implications for human services agencies taking care of their own staff are significant.

Program Philosophy

The staff was asked about their orientation to their work and how they viewed what they did.

The only thing that was introduced to me came from staff. We got together and they introduced me to what they were doing, showed me all the forms. Then they started to introduce me to the families.

So the first couple of weeks I was here, I was just reading and gathering some of the information and then I started to be introduced to the families.

On the job training, no program manual.

Ok, we had an open house to introduce the program and I went to that and got the package and went over that and just went from there.

Just watched and learned as I was going. Learn and listen and listen some more and listen some more.

The mentoring process has been effective as a training tool for new staff. For this orientation process to continue to be effective, mentoring staff needs the time to train and to discuss everything from paperwork to program philosophy with new staff. The current administration supports this. Given that many of the staff were employed when the program evolved, the program philosophy has been passed on in much the same way as a family story.

How Families Changed Since Beginning Program

Many of the clients we spoke with noted dramatic changes during their involvement in the Families First program. Some spoke of how small changes or the addition of routines led to feeling more in charge of their lives; others spoke of working towards major life goals.

When I began, it was a terrible time. I didn't have nothing, no food. We were homeless. Well, living with other people, I didn't have my own apartment, it was awful, I was just off drugs.... and they helped me...helped me find an apartment, get started.

They just help you look at things. They ask about your life, help you look at it, never judgmental, I never felt judged by them. Just that they wanted to help, wanted to make things better. And I was really coming from the bottom, but they never made me feel bad about it, they kept on the positive. It was really something.

Every goal I set that day they came for the first interview, I accomplished. And if it wasn't for their encouragement and support, we probably wouldn't have been able to do it.

For some families the goals helped them connect to an internal resource.

They treated me as in individual, not as a welfare recipient.

They don't see where you are for who you are. Even when things are not too good. This isn't a good week, but we're doing great. We really are. We've come so far.... But they see you for you.

Families maintain that working with staff helped them establish a new perspective and connect with internal resources.

Experiences with the Goal-Setting Process

Clients spoke of the goal-setting process as the template from which they achieved their goals. During the interviews, clients described the goal-setting process as

Very helpful. It puts it in your face. You're looking at it. What step do I need to do next?

Well for me...we just basically wrote down a few things that I had been thinking about. It would be nice to have a house; it would be nice to have a car to make it easier for us as a family, and we just try to work at doing these things.

They (staff) were really good, really good. I mean, they helped, made you look at where you wanted to go and how to get there. I really liked them. They seemed like it really fit my life and, where, how I could do things. I liked them (goal setting). And the goals changed over the years. At first they were very general, a little lost. Now they are very specific.

Staff understood the goal-setting procedure as an orienting tool, helping families to focus on target goals.

Well, we start by asking, "what steps will it take?", When people present generic goals such as a peaceful family, then I ask: "What would peaceful and happy mean to you?"

The goal-setting procedure is central to the Families First model. Staff and families together assess key areas to determine target goals. For the families with whom we spoke, the goal-setting procedure allowed them to recognize that someone understood their struggle (validation). When staff encouraged specific (behavioral) goals, rather than general, such as, "I want to be happy," clients reported having something to work on. The process of writing the goals on paper

followed by frequent reviews helped both staff and clients remain on task, and increased the satisfaction of everyone involved. One staff member described her role as that of a "cheerleader." The power of having someone believe you can do something should not be underestimated. The staff let the clients know they could do for themselves through this goal setting process, much like a self-fulfilling prophecy.

Recommendations from Staff and Clients

Clients perceive staff as masters at introducing ideas of change and different perspectives. Every client interviewed spoke of the benefits of the concreteness of the goal-setting process. However, there is no clear guideline for how often the goal-setting process is reviewed. Some staff "check-in" on goals each visit; others do so much less frequently. One staff member suggested that this process be done more often. While most of the staff viewed the current documentation as necessary and helpful, one voiced that the paperwork needed to be updated.

There is a lot of paperwork and I think that it is too technical.

Participants commented frequently about how the staff would "do anything" to help them. While clearly this added the sense of validation and support that motivated clients felt, both staff and participants acknowledged that there were cases in which the staff were working harder toward change than the clients. One staff commented

I think participants (clients) can do more for themselves, and we sometimes do too much for them.

While staff focused on fine-tuning documentation procedures, client families tended to focus on how to grow the program, reach more people or improve the existing services. This may reflect the clients' satisfaction with the way services are provided and an eagerness to see these services available to others. Clients, who had benefited from the program, spoke of their eagerness to now help others.

I was talking to (friend) and I said, its too bad more of the community couldn't be more involved, because that would make Fitchburg a better place.

They should get a Web site or put ads in the newspaper; a lot of people may volunteer to help. It doesn't have to be in time. They could donate a piece of their yard so people could plant a garden. That's going to help the community.

They could reach out to more people.

Well I thought what could help was to get all the single moms in one room. Whether it's a parenting seminar or something like that to get out.

It would help to have more time for families to get together.

Participants did not have any negative observations about the program and eagerly spoke of how they have benefited from services. When we compared this overwhelming positive response of the interviewees with the responses on the survey, we noted a remarkable similarity.

Client Surveys

Six clients completed a client satisfaction survey ([Appendix B](#)) that captured their satisfaction with the program and how effective it was in helping them meet goals. This was cross-referenced to the interviews from these same clients. Like the interviews, the surveys also indicate a high level of client satisfaction with services.

Table 4: Comparison of Interviews, Satisfaction Surveys and Client Charts

| | Client Satisfaction Survey | Interview | Client Charts |
|-------------------------------|----------------------------|-----------|---------------|
| Goal-setting process: | | | |
| % Setting goal | 100% | 100% | 86% |
| % Partially attained | 100% | 100% | 77% |
| Perception of program: | | | |
| Helpful | 100% | 100% | * |
| Not Helpful | 0% | 0% | * |
| Inviting | 100% | 100% | * |
| Meeting Expectations | 100% | 100% | * |

* Unable to determine from client records; data recorded by staff and may be biased.

Naturalistic Observation

From our observations over the six months that we interviewed clients and spent time at the CAC, it was clear that clients felt comfortable entering the office. Whenever we observed client entering the CAC, they were always promptly welcomed. All staff embraced this welcoming attitude as central to program success. In this way, if one staff is busy, another would quickly jump in, often engaging in small talk until the specific staff person was available. We agree with the clients' perceptions that the staff work well together and that their caring for each other was a factor in program success.

While Families First program staff base their interventions on ideas of empowerment and Solution Focused Therapy (De Shazer et al., [1986](#)), no structured orientation process exists. For staff members who were involved in the program from its start, they reported their approach to working with clients evolved over time. For newer staff, orientation came through observation; they modeled their work on what they observed. This is similar to the model used in medical training: "See one, do one, teach one." Senior staff members serve as teachers to junior staff. The consistency within the program is dependent on staff's communication abilities.

Weekly case reviews tended to be pragmatic with little discussion about philosophy or technique. Staff had ad-hoc consultations and learned from one another's expertise about those families with whom they had difficulty engaging. The staff was comfortable in seeking suggestions for working with clients when there was a concern that racial or ethnic differences might affect the ability to work with a particular client. While staff found this reliance on one another helpful, they were not able to evaluate the effectiveness of the program as a whole in terms of engaging clients. There is no opportunity to evolve engagement techniques for the families they found less motivated. Perhaps the difficulty in connecting with some families can be viewed as a lack of a common "cultural language" with these families. By learning to understand the language of how such families structure their experience, staff would be better able to enter their worlds and join with them.

The Families First clientele we met with seemed to be a very motivated group. Since we entered the project well after many of the clients were engaged, it was difficult to determine if this motivation was evident as they entered the program or if it was a product of an exceptional staff. For many clients, it would appear that progress was a result of some combination of their own readiness and the persistence and personalities of the program staff. Families valued the staff's practical approach and knowledge of resources in the community. Yet what was most important was the support and acceptance they felt from the staff.

Both clients and staff identified the goal-setting procedure as essential. There is a circular relationship among one's description of a problem or goal, what action one then takes, one's further description of actions and results and what further actions one might take (Steier, [1985](#)). For example, if a parent describes a child as "bad," the parent is more likely to use punishment as a solution than other forms of discipline. The behavior of the child will be viewed through the lens of "good and bad" which will then be used to measure whether or not punishment is warranted (Stewart & Valentine, [1991](#)).

When families had copies of their goal sheets, they reported it helped to keep them focused. Client families clearly benefit from this "hands-on" approach. With the introduction of a computerized database to track client progress, we recommend that the staff continue to give clients copies of goals and objectives for them to post prominently in their homes. Through the use of a goal sheet that includes target dates mutually agreed upon, staff could track progress in a way that is tailored-made for each client.

Selves of the Researchers

Given the interactive nature of this research, it is important to provide the reader with information about the researchers in order to understand the bias they bring to the study. As stated previously, both of the authors had a research interest in how the perceptions of clients and staff shape the therapeutic context.

Both of the authors had previous clinical experience working with MOC's Head Start program providing direct clinical services as well as administrative oversight. The researchers shared a philosophical bias towards social construction and narrative models of therapy and, as a result,

the study began with a bias towards understanding the contextual issues that facilitate empowerment.

When we (researchers) began the project, we recognized our bias that staff may inadvertently disempower clients by fostering dependency. We recognized this bias as a product of our prior clinical work with Head Start Families who had been unable to escape from poverty and multi-service involvement in two generations of involvement with Head Start Services. Our experience with the Families First Program was quite the contrary. The research revealed that a number of the staff had "pulled themselves up by their bootstraps" and did not believe it was necessary to "take care" of their clients. It was their view that certain types of caring inhibited the need for clients to take responsibility for their own lives. As a result, staff was very sensitive to what they recognized as a tendency for social service staff to take a pathological view of clients and they worked hard to avoid that trap. This belief was openly discussed throughout our six-month involvement with the program. As we (researchers) met with client families, we directly asked them about their history with other services, what did and did not work. Many of the clients criticized clinicians as being insensitive to their needs, simply doing a job with no personal commitment to their work. Their experiences seemed to leave them open and receptive to the welcoming, solution-focused approach of the Families First staff.

Discussion

The purpose of this study was to evaluate the effectiveness of the Families First program in helping clients achieve their goals and to identify what contributed to success in the program. This was accomplished through the review of client records, the use of interviews, a survey of clients' views and naturalistic observation of an opportunistic sample. This study generated a wealth of information about the experiences of both clients' families and staff. The implications for the program are wide ranging. Of particular interest is 1) the process by which staff help bring that which was "unsaid" to a place of recognition (being said) so that they can successfully conduct it with future staff, 2) how the client and professional's perceptions can affect the delivery of services, particularly those assumptions about one's "right" to receive an entitlement and 3) the relational context in which staff and clients function as partners in a process of change.

Making the Unsaid, Said

When we first started this research, staff had difficulty articulating how they worked with clients. Yet clients returned, made progress and got on with their lives. By immersing ourselves in the program, we witnessed what they were doing and gave it voice. David had first commented on what he perceived as ambiguity in the program, noting "ambiguity is a very familiar phenomenon in human services." He recalled Parsons' (1980) definition of ambiguity as "a lack of structure or the presence of incompleteness or vagueness in a stimulus situation, so that the situation does not elicit the same response from all persons (p. 280)." Lynne did not have the same perception and saw the staff more as adaptable. We wondered if the level of tolerance of ambiguity was a gender issue. So, at the suggestion of the graduate student working with us, we decided to each write about the meaning we attributed to ambiguity in relation to the program. Here are Lynne's comments:

When David and I first began talking about this interpretation of the raw data and what people said about how the program worked, I was surprised by his apparent sense of discomfort in what he termed "ambiguity." He spoke of an uncertainty regarding staff training and in procedures within the program.

Although I also witnessed that nothing was written in stone concerning this program, I was most struck by the flexibility of the staff and the "interactive dance" that clients and staff seemed to be doing with one another. There was an ease in communication and a respect that had governed few such programs that I had seen in my 15 years in the field.

Neither of us had ever adhered doggedly to structure in the past, so these comments surprised me that we would have such a different take on this. Our editor questioned whether this is a male-female thing. I tend to agree that is a factor.

Nevertheless our subsequent discussions on ambiguity, what it is and when it is beneficial, led us to a different way of articulating it. We draw from the notion of therapy (since we are both therapists as well as researchers) the idea of making the unsaid, said. Through the power of language, change is envisioned and the means to the end plotted and tracked.

Given our experiences as therapists, and perhaps our own impatience with the process of change that I'm sure has been nurtured by the managed care climate that we work in, the tasks of the workers may seem endless and their efforts meandering. Yet it is their undying support and conviction that it can be done that shows no ambivalence.

Here are David's reflections, written independently

It is really easy in research and in therapy to get lulled into the belief that we know how things work. As a result, I think of ambiguity as a necessary first step in the work we do. How could it be otherwise if we begin with a position of "not knowing."? I did not come to this project without any information. I have worked with MOC over the past several years as a consulting psychologist to their Head Start programs. As a result, I came to this study with some understanding and experience with the MOC professional staff and client community.

My first impression of the Families First Program was confused. Although both clients and staff spoke very positively about their experiences, there were no clear guidelines that directed their work together. This ambiguity forces us to look more closely at the relationships that exist between people. It is impossible to separate one component of the program from another and say definitively that "this" is the most important. The importance is defined by each participant and cannot be understood without taking the time to listen to his or her individual stories. As a result, the initial ambiguity I felt began to subside as we focused on understanding the experience of those involved.

What we first understood as ambiguity or uncertainty on the part of the staff grew to be understood as a humanistic framework that had not yet been articulated.

The question must be raised of how to reproduce a program whose success is due to the qualities of the staff and the relationships developed between staff and clients. Any attempts at duplication of this program need to highlight the building and sustaining of the relationships in which clients feel comfortable and trusting enough to work on individual goals. Training programs need techniques that develop and encourage the qualities of compassion, caring, intuitiveness and

spirituality that clients spoke of so fondly. While clearly knowledge and skills are essential for the workers, the success of this program is due to the relational context that develops between staff and clients. Staff members take on a mentor-like role, and clients speak of feeling a willing responsibility to meet their goals because the staff supports them so. We used this information to develop a training manual to help articulate a program philosophy and core competencies for staff.

The training manual aims to foster the qualities clients spoke of so highly. One finding that strongly emerged was the feeling that staff believed in them. This was in marked difference to feelings many had had of being "unworthy" of aid or failures for needing assistance. Through historical information and personal exercises, staff is guided to reflect on their own attitudes toward poverty, personal empowerment and the values needed to obtain self-sufficiency.

From the point of social construction theory (McNamee & Gergen, [1992](#)), the staff of Families First does not believe in failure. Setbacks are only problems that need to be solved. After the perceived humiliation of interacting with the welfare office, many clients report that the staff treats them as "equals." One eloquently summed it up as "being treated as a real person, not just a welfare recipient." Clients seem to feel a desire to live up to these expectations.

Perception of Delivery of Services

Why is it that some families are successfully engaged and others are not? For some it may be readiness to change, for others it may be what Imber-Black ([1988](#)) suggests as the often unfortunate ways that families and larger systems interact. She reminds case workers and researchers that it is critically important to pay attention to the patterns that emerge when larger systems attempt to intervene with families. Many families have had ""histories" with other service providers. Unfortunately, a bad experience with a previous provider can lead to distrust in all subsequent helpers. Therefore a more thorough assessment of a family's history of involvement with outside services is valuable in understanding and engaging the "floaters" (a term the staff uses for families who are very inconsistent in treatment) or the difficult-to-engage family. It is important to be persistent but not pushy. The training manual suggests certain language that is helpful to use with such a client and that fosters the sense that the client is master of his or her experience rather than a passive recipient of unwanted services.

Relational Context

Although staff was quick to offer that they were not counselors, many of the skills they used were similar to those used by counselors. Alexander, Barton, Schiavo, and Parsons ([1976](#)), in a study of the influence of counselor characteristics, suggests that relationship and structuring skills accounted for 60% of the variance in counseling outcomes. Relationship skills are defined as a counselor's ability to create an accepting and caring atmosphere. Structuring skills are defined as the ability to control and direct meetings by being direct and clear while conveying a sense of self-confidence. From our review of the data, we conclude staff possesses these skills.

While clients and staff agree that they work well together, it is not clear when their work together is done. One MOC administrator remarked that a family is only finished with the program when

it accomplishes all twelve goals of self-sufficiency. Yet, some clients did not set goals in all twelve areas, and others withdrew or slowly decreased their involvement over time. We asked the staff to reflect on this question of when has a family completed the program. This generated a discussion regarding what success means and who defines it. While wanting to maintain support for clients, staff is also keenly aware that clients need to have a sense of accomplishment and independence. All finally came to the same conclusion that "it's up to the client to know when he or she is done."

From our observations of staff, we conclude staff likes to work very closely with their clients. Five families met with staff monthly. Staff identified two families as "floaters", meaning that contact was intermittent and based on a specific need. Yet, after interviewing one "floater," we concluded she was just too busy in her life making positive changes to have regularly scheduled appointments with staff.

It is also important to note the support that administration gives the line staff. The program supervisor embodies the belief that all workers are doing their best and do not need to "prove to her" that they are working; this probably sets the tone and permission for staff to behave similarly with clients. She readily acknowledges the difficulty of the work and encourages "down time" to prevent "burn-out" in staff. She is sensitive to the needs of staff to balance direct care work, which can often be tiring, with more mundane tasks such as record keeping or case management. From our observations, the staff appears relaxed and there is open communication among all.

Recommendations

Given that the Families First staff has not yet developed a process to track those families who are difficult to engage and as result, this vital feedback is missing, we recommend the following system. Because the majority of referrals are from other MOC programs or agencies with which MOC has frequent contact, a specific release form could be presented at the time of referral that gives permission for Families First staff to call the referral source 30 to 45 days later. At this check-in time, the referral agent could ask the client, with whom the agent has a relationship, to fill in a brief questionnaire about their first impressions of the program (See [Appendix E](#)).

We suggest that the staff conceptualize the program as composed of three phases: Engagement, Active Working, and Maintenance. Those in the first two phases would require more staff time, while those in the maintenance phase might require monthly or fewer visits. Staff function much as the "family doctor," available for periodic check-ups and in times of crisis. By having a framework in which to place clients' status, the program director can better access caseloads and allow for more balanced caseloads and quicker access to services.

We suggest that staff reflect on their own definitions of engagement and see how they correspond with needs of families at particular times. The engagement process should be defined as the time necessary to initiate an active goal-setting process toward self-sufficiency rather than by the frequency of contact. Understanding engagement as goal focused may also aid some of the families who have experienced human service workers in general as intrusive.

There is no formal process for tracking the progress of the program as a whole. Client data should be evaluated at each of the key Benchmarks (one month, three months, six months, one year); this schedule allows for comparisons of client success for each of these cohorts. We suggest that data be tracked for each client on the following form.

Client Tracking Form:

Client:

Entry Date:

Difficulty of Engagement: (1=hard to engage; 5= easily engaged)

1 2 3 4 5

Is the client keeping appointments (75% of the time)?

Strategies for increased engagement (if necessary):

- 1.
- 2.

One-month status check: (please circle)

Engaged Active Hesitant

Which areas has client set goals for?

- 1.
- 2.
- 3.

Three-Month Status check: (please circle)

Active Hesitant

Percentage of goals attained? _____

Six-month check in: (please circle)

Active Maintenance

Percentage of goals attained? _____

One-year check in (please circle)

Active Maintenance

Percentage of goals attained? _____

Remaining goals:

By looking at statistics of the present client base, staff can create a set of expectations for engagement of clients and for goal attainment that is both reasonable and allows staff to track the progress of the program as a whole. We suggest the following benchmarks to evaluate program success:

- Client engagement at one month: 70%
- Client engagement at three months: 85%
- Percentage of clients reaching one goal by three months: 75%
- Percentage of clients reaching half of goals by six months: 75%
- Percentage of clients reaching 75% of goals by one year: 75%

These percentages are consistent with those suggested by other state-funded agencies such as the Department of Mental Health. The following were incorporated into the training manual to help create the relational context that we observed in the present staff-client interactions:

- Suggestions derived from our interviews with clients about their previous experiences with helping systems for engaging the hard-to-reach client
- Suggestions to establish ways for the experience with previous agencies to be different
- Values clarification exercises on one's attitudes toward helping, public assistance, and the process of judgment
- Development of an understanding of one's strengths and challenges, how to use them to empower one's work with clients, and a definition of the comfort zone of sharing with clients
- Clarification of one's boundaries about the use of self in working with clients
- Development of the skills for solution-focused work with an emphasis on problem solving
- Skill development sections on interviewing, and assessing for safety in domestic violence, suicidality, and substance abuse

Summary

The purpose of this study was to understand the meaning ascribed by both the families and professionals in their experience of the Families First program. Families and professionals begin the process of involvement with certain assumptions that influence their understanding and expectations. Making explicit these assumptions and clarifying any ambiguity acknowledges that all participants must share in the evolution of the service system. This process not only provides for ongoing assessment of the program, but also provides MOC with valuable information that can be used to expand the range of the program's success.

References

Alexander, J. F., Barton, C., Schiavo, R. S. & Parsons, B. V. (1976). Behavioral interventions with families of delinquents: Therapist characteristics and outcomes. *Journal of Consulting and Clinical Psychology*, 44, 656-664.

American Psychological Association (1982). *Ethical principles in the conduct of research participants*. Washington, DC: American Psychological Association Press.

Anderson, A., & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process*, 27(4), 371-394.

Andreozzi, L. L. (1985). Why outcome research fails the family therapist. In L. L. Andreozzi (Ed.), *Integrating research and clinical practice* (pp. 1-9). Rockville, MD: Aspen.

Atkinson, B. J. (1992). Aesthetics and pragmatics of family therapy revisited. *Journal of Marital and Family Therapy*, 18(4), 389-393.

Denzin, N. K. (1983). Interpretive interactionism. In G. Morgan (Ed.), *Beyond method: Strategies for social research* (pp. 129-146). Beverly Hills, CA: Sage.

DeShazer, S., Berg, I. K., Lipchick, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process*, 25, 207-222.

Fitchburg State College. (1997, June). *Capacity building for sustainable communities*. (Available from the Grant Center, Fitchburg State College, 160 Pearl St., Fitchburg, MA 01420).

Gilgun, J. F., Daly, K., & Handel, G. (Eds.). (1992). *Qualitative methods in family research*. Newbury Park, CA: Sage Publications.

Guba, E. G. (Ed.) (1990). *The paradigm dialogue*. Newbury Park, CA: Sage Publications.

Heron, J. (1981). Philosophical basis for a new paradigm. In P. Reason & J. Rowan (Eds.), *Human inquiry* (pp. 19-35). New York, John Wiley.

Honigman, J. J. (1970). Sampling in ethnographic fieldwork. In R. Naroll & R. Cohen (Eds.), *A handbook of method in cultural anthropology* (pp. 266-281). Garden City, NY: Natural History Press.

Imber-Black, E. (1988). *Families and larger systems*. New York: Guilford Press.

Keeney, B. P., & Sprenkle, D. H. (1982). Eco-systemic epistemology: Critical implications for the aesthetics and pragmatics of family therapy. *Family Process*, 21, 1-19.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.

Locke, L. F., Spirduso, W. W., & Silverman, S. J. (1987). *Proposals that work*. Beverly Hills, CA: Sage.

McNamee, S., & Gergen, K. J. (Eds.) (1992). *Therapy as social construction*. London: Sage.

Miles, M. B., & Huberman, A. M. (1984). *Qualitative data analysis*. Beverly Hills, CA: Sage Publications.

Parsons, M. (1980). The risk of breakdown during outpatient psychotherapy. *American Journal of Psychotherapy*, 34(2), 153-163.

Patton, M. Q. (1989). *Qualitative evaluation methods*. Beverly Hills, CA: Sage Publications.

Pearce, D., Russell, L. H., & Brooks, J. (1998). *The self-sufficiency standard for Massachusetts: Executive summary*. Boston, MA: Wider Opportunities for Women.

Schram, B., & Mandell, B. R. (1997). The social welfare system. In *Human services: Policy and practice* (3rd ed.) (pp. 194-254). Boston: Allyn and Bacon.

Seidman, I. E. (1991). *Interviewing as qualitative research*. New York: Teacher's College Press.

Steier, F. (1985). Toward a cybernetic methodology of family therapy research: Fitting research methods to family practice. In L. Andreozzi (Ed.), *Integrating research in clinical practice* (pp. 27-36). Rockville, MD: Aspen Systems.

Stewart, K., Valentine, L., & Amundson, J. (1991). The battle for definition: The problem with (the problem). *Journal of Strategic and Systemic Therapies*, 10(2), 21-31.

Appendix A: Semi-Structured Interview

Do you remember how you first found out about Families First?

Could you tell us about your first contact with a Families First staff person?

Are there any images that particularly stand out for you about those early contacts?

We are curious about what is your understanding of the purpose of the Families First program?

How would you describe what it is that (staff person's name) does when she meets with you?
How specifically does she do this?

How would you describe your role?

What has been most helpful to you from the Families First program? Can you think of ways that may have been more helpful to you in that situation?

We are curious about how goals are established. Could you walk me through this process?

How would you describe your relationship with Pam (Genevieve, Wanda)?

How did you and Pam (Genevieve, Wanda) go about defining what you would work on together?

Were other family members involved in the decision?

What is your understanding of how the Families First team works together? Has Pam (G, W) helped you with any involvement with other agencies (for example, DSS or getting a GED)? How helpful was that?

If you were designing the Families First program, what would you keep the same? What would you change?

The staff always tells us that they are not counselors. What is your understanding of how this program deals with people when psychological problems arise?

Appendix B: Client Satisfaction Survey

After reviewing your original Family Plan, which goals have you achieved?

What helped you most to achieve these goals?

Which do you feel you have not yet achieved?

Why do you feel you have not achieved this goal?

What could the program have done differently?

Do you feel that these goals still apply?

What would you like to change?

What has been the most helpful to you about this program?

What has been the least?

Has the program met your expectations?

Is there anything that you would change?

How can we make this Families First work better for you?

More meetings?

Fewer meetings?

Meeting other families?

Workshops?

Outings?

Newsletter?

If you would be interested in workshops, what topics would be most helpful?

Parenting issues:

Discipline

Attention Deficit Disorders

Childhood illnesses

Nutrition

Health

Finances

Budgeting
Building support networks

Jobs:

Skills and job matching
Resume writing

Interviewing techniques

Education:

Financial Aid
Applying to schools
Selecting a college/major

Appendix C: Research Methodology

The process of knowing is an interactive one between participant and researcher from which one cannot remove oneself. It is through interactions and dialogue between researcher and participant(s) that information is generated and interpreted. An emphasis on process, rather than "objective" labeling of events or behavior, makes the naturalistic paradigm compatible with the goals of this study. Denzin ([1983](#)) notes that while traditional researchers "separate themselves from the worlds they study, the interpretivists participate in the life world so as to understand better and express its emergent properties and features" (p. 133). Given the differences in the kind of data collected, methods of interpretation and validation should account for the depth of information. Therefore, for the purposes of this study, alternative terms for traditional measures of validity and reliability as defined by Lincoln and Guba ([1985](#)) are used: "credibility" rather than validity; "transferability" rather than applicability; "dependability" rather than consistency; and "confirmability" rather than objectivity.

Traditional notions of validity focus on the instruments themselves with little reference to factors that occur in the administration of the research. Because we acted as human instruments, validity of findings lies within our interaction with the participant(s). Through a period of prolonged engagement (Lincoln & Guba, [1985](#)) in which we invested enough time to truly understand the "culture of the project," we were able to sort out faulty, distorted or fragmented information and solicit additional feedback from participants.

Given the lack of norms and quantifiable standards in naturalistic inquiry, the qualities that would be compared between the study group and another group for determining generalizability are not captured by simple demographics. Lincoln and Guba ([1985](#)) suggest that all information is a "time- and context- bound working hypothesis" (p. 37); generalizations cannot be made without careful consideration of the similarities and differences of many contextual factors. We refer the reader to the description of the sample when determining whether a client population is similar enough to the one in this study to make program duplication feasible.

In qualitative studies, variance is not an "objective instrument", but in the researchers themselves and in their interactions with participants. Therefore, we as researchers must be attentive to our own states, including such distractions as fatigue, annoyance or hunger. Lincoln and Guba's parallel criterion for reliability, "dependability", requires researchers to "account (for) both facts of instability and factors of phenomenal and design-induced change" (1985, p. 299). Rather than trying to exclude our influence from this project, we acknowledged it as part of the analysis. During the interviews, a primary distraction was the presence of small children who often wanted our attention. Toys and promises of playing afterwards sometimes held off interruptions. At times like this, it was particularly helpful that we were working together; one of us could stay focused on content while the other handled the distraction. Although some interviews were conducted in participants' homes and others were done at the Families First office, different sites do not appear to constitute a confounding variable. Participants were asked for their preference of interview site.

Through an inquiry audit (Lincoln & Guba, 1985), an auditor reviewed the raw data to determine if the study was undertaken in a careful and systematic manner and if the analysis and constructions of the researchers made sense. The role of the inquiry auditor is to:

examine the process of the inquiry, and in determining its acceptability the auditor attests to the dependability of the inquiry. The inquiry auditor also examines the product -- the data, findings, interpretations, and recommendations -- and attests that it is supported by the data and is internally coherent so that the "bottom line" may be accepted. This latter process established the confirmability of the inquiry. (Lincoln & Guba, 1985 p. 318)

An audit trail that evaluates raw data addresses concerns of dependability by checking if the analysis is verifiable.

While the traditional researcher strives for objectivity, the researcher in naturalistic inquiry acknowledges that it is impossible to eliminate his or her influence. Lincoln and Guba (1985) suggest that a study's "confirmability" (p. 300) is defined by how well the analysis fits with the data and how easily another researcher looking at the same materials could come to similar conclusions. When personal biases exist, they are acknowledged so that another researcher using the data can do so in an informed manner.

Atkinson's (1992) guidelines for therapist client interactions were incorporated into the semi-structured interviews. His four principles are

1. Therapists should be careful to present their views as their opinions, not objective facts, and avoid words like "obviously" or "clearly."
2. Therapists should make sure that clients know that their views do not necessarily represent the consensus of other therapists in the profession.
3. Therapists should invite each client to evaluate the therapist's ideas based on how sensible they are to the client, not based on how authoritative or confident therapists seem to be.
4. Therapists should explicitly invite clients to disagree and to take an active role in creating ideas that make the most sense to them (p. 390).

Finally, and perhaps most importantly, we have attempted to capture the experience of those involved in the Families First Program. In this attempt, it must be understood that our views are not the only "correct" perspective, but rather one part of collaborative inquiry.

Appendix D: Informed Consent

We, David Haddad, Ed.D. and Lynne Kellner, Ph.D., are currently conducting an evaluation of the Families First Project as coordinated by the Montachusett Opportunity Council (MOC). This study will help us gain valuable feedback on what has been helpful and what has not been for your family as it has participated in the project. The evaluation is intended to assess the effectiveness of the interventions and not to make assessments of individual clients. Ultimately, this information will help us to work with the MOC staff in revising its program manual for the Families First Project. The researchers also request permission to use data generated from the interviews to present to the Department of Housing and Urban Development (HUD) which has helped fund this project. This material will be essential in obtaining future funding.

Your participation would involve a semi-structured interview with your family.

Participation in this study is completely voluntary and any family member may withdraw from the study at any time. Your time is greatly appreciated and preliminary findings of the research will be available to you as the evaluation progresses.

To assure accuracy in recording your responses, interviews will be audiotaped; these tapes will be used for research purposes only and will be held in strict confidence. MOC will retain the tapes for a period of five (5) years; the American Psychological Association ([1982](#)) establishes this time period. Afterwards they will be erased.

All information will be strictly confidential; pseudonyms will be used to protect the identities of the participants and all identifying information will be disguised to ensure the privacy of participants.

In signing this form, I am also giving permission for my minor child(ren),

to participate in the study. I understand that my child or I may withdraw permission at any time, in writing, prior to completion of the study. Upon completion, a summary of the results will be available to each family desiring one.

Participant, Date

Child Participant, Date

Witness, Date

Appendix E: Questionnaire for Program Referrals

Client:

Date of Referral:

Date of Follow-up:

Referral Contact and Agency:

Referral Agent's Assessment of Services Sought:

<p.

Client's Assessment of Services Sought:

Barriers to Involvement:

___ Accessibility

___ Worries about possible involvement with other agencies (For example, DSS)

___ Other (please specify)

Client's Experience with Families First Staff:

This form was completed by

_____ (Client)

and _____ (Referral Agent)

Please return to: Community Action Center
405 Main Street, Fitchburg, MA 01420 Attn: _____

</p.

Author Note

⁺*Lynne A. Kellner, Ph.D.*, is an Assistant Professor of Behavioral Sciences at Fitchburg State College. She received her Ph.D. in Counseling Psychology from the University of Massachusetts at Amherst. She has worked as a Child and Family Therapist for more than 15 years; her research includes the development of a systemic model of resiliency in children and the creation of a co-constructivist model of treatment for sexually abused boys. She can be reached at Fitchburg State College, 160 Pearl Street, Fitchburg, MA 01420; or by phone at (978) 665-3259 or at lkellner@fsc.edu.

⁺*David Haddad, Ed.D.*, is a psychologist / consultant in private practice. He received his doctorate in Counseling and Consulting psychology from the University of Massachusetts at Amherst. As a consultant he has provided direct service, teaching and program development to public and private systems, inpatient and outpatient providers, and hospital systems. He is adjunct faculty at Fitchburg State College, Antioch New England Graduate School and Cambridge College. He can be reached at dhaddad@net1plus.com.

⁺*Ann G. Forcier* was a graduate student in mental health counseling at Fitchburg State College and is a freelance writer and editor.

This project is a product of the Community Partnership Outreach Center at Fitchburg State College, which was funded through a grant from the Department of Housing and Urban Development.