Family Thriving Program (FTP)

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I. History of FTP

A. History of Relevant Research Involving FTP

The central goal of the FTP emerged from D. Bugental's program of research on the effects of perceived power of parents within the caregiving relationship. Across a series of laboratory and community-based studies, parents (or teachers) with low perceived power in the caregiving relationship were found to be more likely to respond with "threat responses" to children who posed a challenge (either as a function of their physical or medical conditions, or temperament pattern). At-risk children within this research included: preterm children, children born with birth complications, and children who were unresponsive to caregiver influence attempts. Parental "threat" responses included: activation of physiological threat systems (e.g., increased cortisol levels, increased HR), and increased use of harsh, avoidant or neglectful parenting.

The FTP was designed to constructively "empower" parents in at-risk families (either at a result of the risk level of parents, or the risk level of their children). In the first test of the program, the population consisted of at-risk parents (who had a history of experiencing low access to personal, economic and social resources). In the second test of the program, the population involved children who were at-risk at birth (as a result of preterm status, or presence of medical conditions or birth history that made them eligible for placement in an NICU or for more than usual medical attention after leaving the hospital.

In the first test of the effectiveness of the program (Bugental et al., 2002), a comparison was made of the effectiveness of the FTP versus (1) a Healthy Start Program (HSP) and (2) control condition. Child abuse during the first year of life was found be significantly lower (4%) in the FTP than either the HSP (23%) or control condition (25%). A similar pattern of outcomes was found for (1) reductions in use of harsh parenting (e.g., spanking), and (2) reduced indications of neglect. In addition, mothers showed lower levels of depression, which in turn served to mediate the reductions in maternal use of harsh parenting tactics.

In the second test of the effectiveness of the program (Bugental & Schwartz, 2009), a comparison was only made of the effectiveness of the FTP versus the HSP program. In the first year of life, use of harsh parenting was found to be less in the FTP than the HSP program. Children

were also found to demonstrate lower levels of basal cortisol in the FTP than the HSP program. The implementation of the program was identical during the first year for both tests of the program. In the first test of the program, outcome measures were limited to the end of the first year. However, in the second test of the program, outcome measures were obtained when children reached age 3. Comparisons included an assessment of the cognitive and social functioning of children. Children in the FTP were found to show higher levels of cognitive functioning (increased memory) and a reduced level of externalizing problems. A key mediator of increases in children's memory was the reduction of their cortisol levels (during infancy). A key mediator of reduction in children's externalizing problems was the reduced level of maternal levels of depression.

B. Past Implementation of the FTP in the Community

The FTP was designed as an add-on to the Healthy Start Program. Whenever any inconsistency appears across programs, the goals and timing/scheduling of the HSP program were retained but the method of achieving them was altered.

As a potential difference between the FTP and HSP, possible resolutions to identified problems are more likely to emerge from the home visitor in the HSP program, whereas possible resolutions always come from the parent in the FTP program (as facilitated by the home visitor). In short, the home visitor in the HSP program is more likely to be a ***provider*** of possible resolution whereas the home visitor in the FTP is more likely to be a ***facilitator*** of possible resolutions. For example, the home visitor in the HSP program might provide information to parents about (1) stages of expected child development, and (2) sources of additional help in the community. In the FTP program, the home visitor acts to facilitate parental information-search processes, i.e., ***how to search*** for information on child development, and community resources. The guiding motivation in this effort was to empower parents to function effectively as caregivers on their own at the conclusion of the intervention.

In order to understand the basic premise of the program, here is a well-known maxim that can be adapted to explain the rationale for the FTP method in everyday language:

Maxim: Give a man a fish and he eats for today. Teach a man to fish and he eats for the rest of his life.

Adaptation of maxim: Provide direct help in solving someone's problem, and that immediate problem will be solved. Demonstrate (repeatedly) how to search for problem resolution, and the person will become a life-long problem solver.

Home visitors in the FTP always began their visit with an inquiry about recent challenges experienced by the mother (as described in the Protocol). When implementing the HSP program, home visitors followed methods consistent with that program.

1. Home visits

Home visits were scheduled to suit the availability of mothers (we have only been successful in involving mothers in the program) and the home visitor. This was never easy. Due to the nature of the population, scheduling exact times for events was not a common experience. There were 17 regularly scheduled visits (up to 3 additional visits were allowed if a special need arose). The visits typically lasted about an hour. The total cost of this one-year program was approximately $4,000 per family. The cost savings ratio was approximately 4:1.

Home visits usually occurred in the home. Home visitors did their best to arrange the meeting so that the conversation just involved themselves and the mother. This was not an easy task. It involved such resolutions as meeting with the mother on the front steps, the bathroom, on a walk, etc.. When other family members insisted on being there, the home visitor acceded to the request but brought it up at our weekly meeting to figure out a resolution. In one such insistence, several male relatives of the mother wanted to join in the meeting. In a subsequent team meeting, the idea emerged that the men might be worried about the welfare of the mother and baby. The home visitor brought this up with the men at the next meeting, and indeed they were afraid that the home visitor would kidnap the baby (a not entirely irrational fear in connection with the frequency of kidnapping infants for sale in other countries – a more prevalent occurrence in the population involved). When assured they could stay close by (but asked not to be in the same room), they became more comfortable, and soon stopped showing up at all.

Sometimes visits could not be scheduled at home. One mother worked all day and was not available on weekends. The home visitor met with her in a local restaurant at her lunch break. Another mother was a field worker. The home visitor visited her in the field during work breaks.

2. Selecting Home visitors

Home visitors were selected on the basis of: (1) education (a B.A. in some area of the social sciences), (2) a positive view of scientific methods (important for implementing the research component of our program). (3) a bilingual, bicultural background (for those serving a Latino population), (4) past experience with infants and young children, and (5) gender (we began he program with one male home visitor but in this population, husbands refused to let a man be alone with their wife in their home)

3. Training Home visitors

Equivalent general training was provided to home visitors during both its first (Bugental et al. 2002) and second implementations (Bugental & Schwartz, 2009). In both cases, they received training in basic Healthy Start methods. This included information about issues that emerge in parenting during a child's first year of life. The central difference in the second implementation was that additional training was provided specific to children born at medical risk. Local staff of Easter Seals provided the most valuable training in this connection.

Role-playing provided the central component of training of the FTP intervention (see Protocol for details). We set it up so that trainees took turns (1) playing a parent experiencing a problem, (2) acting as the home visitor, and (3) being an observer. We found that home visitors (when being trained) noticed that they were -- unintentionally -- going through the FTP problem-solving sequence in their own lives and with their own issues.

Early in the program, when the home visitors had considerable free time, they compiled (and shared) community information (e.g., programs available for parents, children, and for families lacking in resources) and potentially useful books or materials for new parents. When useful, contact was made with community agencies to obtain further information. Home visitors also sought information to increase their own understanding of infant development. Later in the program, guests with specific expertise (e.g., a lawyer who had provided help to immigrants who were subject to

scams, the Director of Child Protective Services, a pediatric neurologist) were invited to team meetings to make presentations.

4. Supervision and Fidelity

Weekly supervision was a key component of the program. In addition, a clinical psychologist familiar with the program and the home visitors was always on call for an emergency, or for guidance with any kind of problem that might be serious, for example, depression. A public health nurse was also available in connection with medical problems.

Weekly supervision had two components. First, home visitors met individually with a clinical supervisor to discuss the families they had seen most recently, and the methods they had used in implementing the intervention (either FTP or HSP) as well as discussing any concerns. They also met in joint session with the clinical supervisor and the Director. This time period was very important in brainstorming more difficult problems. Home visitors also provided examples of the kinds of problems that had come up. and how they had worked them through in the FTP condition. Home visitors were (successfully) kept blind regarding our expectations concerning the differential outcomes of the two programs.

Fidelity was managed through weekly meetings concerning ways in which the program was implemented with each specific family (as recorded in home visitors' case notes). Although our original plan had been to audiotape the section of the visit that included a discussion of a recent problem, this led to concerns that could have interfered with the program. Mothers (most of whom were undocumented immigrants) feared this could make them vulnerable to identification by Immigration Services.

4. Measures Taken at Intake

Client Information

Mom______________________ D.O.B.__________ Baby 1 Name_____________________

FOB______________________ D.O.B.__________ Baby 2 Name______________
(father of baby)

Others (Partner, Siblings):

__________________________ D.O.B.__________ Phone 1_______________
relation

__________________________ __________ Phone 2_______________
relation Address:

__________________________ __________ ______________________
relation

__________________________ __________ ______________________
relation

Client ID (family code) ____ Condition 1 (A) 2 (B)

Home visitor 1 2 3 4

Baby D.O.B. _______________ Baby's Age (today)__________

Reason(s) for referral:____

_______________________________ Discharge date: _____________

Gestation_____________ C-sect. 1(Yes) 0(No)

Baby (1)	Baby (2)
Apgar (1) __ Apgar (5)__	Apgar (1) __ Apgar (5)__
Head Circ._______	Head Circ._______
Birth Wt.________	Birth Wt.________
Diagnosis:	
0 1 premature	0 1 premature
0 1 respiratory distress	0 1 respiratory distress
0 1 meconium aspiration	0 1 meconium aspiration
0 1 other _______________	0 1 other _______________
Gender 0 (F) 1(M)	0 (F) 1 (M)

Baby Ethnicity 1 white 2 latino 3 african american
4 asian 5 native american 6 other _________

Living Arrangements:

1 married, living together 2 married, separated 3 single
4 living with FOB 5 living w/ another male

Mom's Info:

Age (today)______

Ethnicity: 1 white 2 latino 3 african american
4 asian 5 native American 6 other _________

Education (years)______

FOB Info:

Age (today)______

Ethnicity:	1 white	2 latino	3 african american
	4 asian	5 native American	6 other ________

Education (years)______

Mom's Kempe

1.	0 5 10	6.	0 5 10	Score______
2.	0 5 10	7.	0 5 10	
3.	0 5 10	8.	0 5 10	Normal (20 or less)
4.	0 5 10	9.	0 5 10	Mild (21-39)
5.	0 5 10	10.	0 5 10	Severe (40 or more)

C. References

1. Outcomes of the Family Thriving Program

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2. Other Relevant References

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Bugental, D. B., Martorell, G. A., & Barraza, V. (2003). The hormonal costs of subtle forms of infant maltreatment. *Hormones and Behavior, 43*, 237-244.

D. Other Sources of Information on FTP

1. **Rand Corporation summary of FTP as an example of a "proven program"**
   http://www.promisingpractices.net/program.asp?programid=271

2. **Bugental website**
   http://www.psych.ucsb.edu/~bugental/).

By September, 2011, streaming videos will be provided that show:

1. A home visitor talking with the Director about her experiences with FTP

2. A supervisor talking with a home visitor about a continuing issue with one of the families.

3. Two simulated examples of interaction between a home visitor and a mother in the FTP.

II. Protocol

A. Training in FTP Methods

1. Basic approach

The FTP approach involves figuring out the reasons for, and potential ways of resolving a recent caregiving problem. This discussion is always introduced at the start of a home visit. if other problems are identified later during the visit, the same approach is employed. In the history of the program, significant problems were more typically introduced by mothers later in the visit (and thus should be noted in case records).

Problem-solving discussions are designed to empower parents to manage the everyday events of caregiving. The first goal is to assist parents in identifying recent caregiving challenges they have experienced, and then considering the possible causes of those problems. After identifying a recent problem (either at the start of the visit, or as the problem is mentioned during the course of the visit), the parent is asked for their view of the reasons for the problem. They are encouraged to think of a variety of reasons -- in search of a potential reason that does not involve blame (of self or others) and that is amenable to potential resolution efforts. As soon as the parent identifies a "resolvable" type of cause, the home visitors shifts the topic to consideration of potential resolutions.

The second goal is to assist parents in generating possible solutions for *"difficult"* caregiving experiences. By coming up with their own ideas—and then testing them out—parents gain experience in an effective problem-solving process. That is, they gain practice in coming up with ideas about the child's feelings and motives, and acquire a sense of mastery and competence as a result of reaching resolutions. After a potential problem is decided, the parent implements and then reports back during future home visits regarding its success (or lack of success). In many cases, the potential resolution requires "fine-tuning." In other cases, a new approach will be considered and attempted. Parents are reminded at future visits of their own resolutions when a similar problem arises in the future.

Mothers are assisted in (1) figuring out alternative causes of a problem (e.g., shifting away from assuming that a fussy child is being stubborn -- by considering a variety of interpretations), (2) deciding on a possible resolution to

try, and (3) observing the outcome of the potential resolution. This entire process helps parents to generate hypotheses about their children's motives, why the caregiving experience is "difficult" at times, and what kinds of changes might be implemented that reduced the problem.

Mothers are also assisted in considering how one might know what infant is thinking/feeling (e.g., do infants have different cries for different sources of distress?), and how one might determine whether a potential problem-solving resolution is successful (e.g., does the child now show more instances of positive behavior -- and what is the range of responses that a child could show that indeed reflect a positive state). In short, they are assisted in ways of obser*ving their children and figuring out what the child may be experiencing.* This process (which has been called "cue detection" or "baby reading") involves searching for cues that (1) the child is interested in interacting with others, (2) the child is interested in exploring the physical world around them (by sight, touch, or movement). (3) the child does *not* want to interact with others, or (4) the nature of the child's distress (e.g., that he or she is fearful or wary, experiencing pain or discomfort, frustrated, overwhelmed, hungry, tired, or bored).

2. Role playing

Before beginning role-playing, it is important that those being trained capture the sense of the approach. Some suggestions for facilitators of training include:

1. Have trainees think through what they do when a friend tells them about a problem. Typically, they will offer advice or helpful information. If they have a clinical background, they may "reflect" what they believe the person appears to be feeling. ***Neithe***r of these approaches is consistent with FTP procedures, and it is pointed out to trainees that they will be learning a new approach.

2. The problems trainees come up with can be based on their own clients (if they have history working with families), their own past experience as a parent, or problems reported to them by their friends.

In preparing to conduct problem-solving discussions with parents, the trainee will start by role-playing such interactions with their supervisor and other trainees. They will take turns playing the part of a parent or the home visitor. The group will start by making a list of the kinds of some of the positive and negative experiences one might have with a young infant, e.g.:

The infant looks away or turns away from the caregiver when spoken to.

The infant produces a sudden loud cry and turns rigid when his diaper or clothes are being changed.

The infant cries and cries, and nothing seems to help.

The infant pulls away or stiffens when picked up.

The person playing home visitor will start by asking, *"So how has everything been since I visited last?"* The person playing the parent will then come up with a *"problem," e.g.,"Johnny pulls away from me when I try to pick him up."* On inquiry as to why that might be, the mother might say, "Because he doesn't like me." The home visitor will then follow this up with questions about the cues the mother used in deciding what Johnny wanted and felt. This would then be followed with an inquiry as to other reasons that a child might pull away from a parent. Whenever a parent comes up with a blame-oriented explanation, the home visitor will pursue other possible causes of children's reactions until a "benign" explanation is offered.

Next, the home visitor follows up with the question, *"What are some of the things you have heard about or thought about that might help?"* After the parent comes up with a list, the home visitor asks them what they would like to try in the next week or so, and how they would knot the problem had or had not been resolved. She then winds up by saying that the parent can report back next time as to how it all worked out. Listed below are some examples of problems/challenges mentioned by mothers in our history with the program:

"My baby is only 3 months of age and he's already talking back to me."
Home visitor query – "What he is doing"
Mom: "when I say something, he makes a sound back."

"My baby cries no matter what I do."
Home visitor query – "Why do you think that is? "
Mom "He is mad at me."

"My baby likes my mother better than he likes me."
Home visitor query – "What makes you think so?"
Mom "When I come home at night after work he would rather be with my mother than me."

"My baby is afraid of my ex-husband."

Home visitor query -- “What makes you think this?”
Mom: “He fusses for no reason when my Ex- is coming over”

All of these examples provided a basis for making an inquiry relevant to “baby reading” and could be use for a shared search through a helpful videotape or book on parenting, e.g., looking for information on such topics as: when babies start “communicating” (returned smiles, sounds, etc.) with their parents, why babies cry, baby’s response to separation from parent, emotional contagion from parent to child.

2. Home Visits

For all visits to the family (after your first introductory visit), the home visitor should start with the problem-solving discussion. This discussion should follow the same format shown above. That is, the home visitor should first focus on what problems have occurred, and determine what the mother believes is causing this problem. In doing so, the home visitor should seek information on what child cues the mother uses to decide what a child wants or feels. Finally, the home visitor asks the mother what potential resolution she would like to try. The success of this resolution is then discussed at the next meeting.

On return visits, the home visitor should always begin with a discussion of how the previous problem-solving efforts worked out (and should check their notes to see what that mother was going to try). If they feel the mother is making headway on the issue, this should be recognized, e.g., *“It sounds like you and Johnny are getting there.”* They should then move on to questions regarding other issues that have come up that need attention. If they feel the mother has not been making progress, they should shift to a discussion about shifting to try something different (or, if the mothers prefers, try a little longer with the approach she is using).

Sample Scenario

Home visitor: *So how has everything been with you and Johnny this last week (or time period since last visit)?*

Mother: *It’s been tough. He just cries and cries during the night and nothing I do seems to help. I am just so tired.*

Home visitor: *What do think is going on? Why do you think he cries so much?*

Mother: *I don't know. He just cries. I don't know why.*

Home visitor: *What do you try doing?*

Mother: *Well, I feed him.*

Home visitor: *So you think he cries because he's hungry. Does it work?*

Mother: *Sometimes he cries right away after I feed him. I try to burp him but that doesn't help.*

Home visitor*: Well, let's do a little guessing here. If he cries after you feed him, why might that be?*

Mother: *I don't know. Maybe his stomach hurts. Maybe he just doesn't like my milk.*

Home visitor: *Does he cry differently for different things? Does he sound the same when he's hungry as when something hurts?*

Mother: *Well, yes. When he's hungry, he starts with just a little fussy sound. Then it sort of builds – it gets louder and longer.*

Home visitor: *What about when something hurts?*

Mother: *Well, the only time I can think of is when the nurse stuck his heel with a needle. He looked sort of mad and his cry was sudden and really loud.*

Home visitor: *So when he cries after you feed him, it sounds more like something hurts, right?*

Mother: *Yeah, I guess so.*

Home visitor: *Okay, now let's figure out what you might do here. If a baby's stomach hurts after eating, what do you think might help – or what have you heard your friends or family members say?*

Mother: *Oh, people say lots of things. Some people say, "Just let him cry it out." Or I have one friend who takes her baby for a car ride when he gets to crying and crying. Another of my friends said there was something*

about problems with the formula she was using – but I'm breastfeeding him. And one of my relatives said that babies calm down if you put them on their stomach and massage their back.

Home visitor: *What do you think you would like to try?*

Mother: *Well, I think maybe I'll try massaging his back. And I see my pediatrician next week so I'm going to ask her if she has any ideas about what's wrong.*

Home visitor: *Okay, great – that sounds good. Try it out. Next time you can tell me how it worked out.*

3. Timeline

LEVEL 1 (Birth through 4th month): two visits/month

Home visitor responsibilities:

- Intake visit: Conduct assessments.
- Visit families every other week (on the weeks that no visit is made, telephone contact is made by home visitor).
- Meet weekly with clinical supervisor: Inform supervisor of initial intake and discuss information provided.

Family Goals:

- Client keeps appointments with home visitor, or calls to reschedule at least 75% of the time.
- Client demonstrates the ability to consider caregiving problems and the potential reasons for those problems.
- Client has made contact with agencies that they have learned may be able to provide supplemental assistance.

LEVEL 2 (5th month through 8th month): 1 visit/ month

Home visitor responsibilities:

- Visit families once a month (make phone call every other week).
- Meet weekly with clinical supervisor: Inform supervisor of family progress and discuss problems.

Family Goals:

- Client keeps appointments with home visitor, or calls to reschedule at least 75% of the time.
- Client demonstrates ability to implement positive problem-solving skills and "cue detection" methods.
- Client maintains contact with agencies with which they have made contact for supplemental assistance.
- Client takes infant to all scheduled well baby care appointments, and to the doctor when ill.
- Infant's immunizations are up to date.

LEVEL 3 (9th month through 12th month): Bimonthly visits

Home visitor responsibilities:

- Visit families every other month (make phone call every other month).
- Meet weekly with clinical supervisor: Update clinical supervisor with respect to progress of family.

Family Goals:

- Client keeps appointments with home visitor, or calls to reschedule at least 75% of the time.
- Client uses at least two positive support networks.
- Client maintains contact with agencies with which they have made contact for supplemental assistance.
- Client takes infant to all scheduled well baby care appointments, and to the doctor when ill.
- Infant's immunizations are up to date.
- Client shows ability to initiate problem-solving sequence even in the absence of the home visitor.

ADDITIONAL VISITS:

Up to three additional visits may be made to families under special circumstances, that is, when there is some special crisis or need (to be discussed with clinical supervisor).

Timeline Checklist

Client I.D._______ Client Name_____________________

Level 1 start date _ Level 2 start date _ Level 3 start date _

Date Completed	Level/Mo.	Week	Task
_____	1/1	1	Consent to Participate Client Information Introduce Self, Program Set up Appts. for Initial Assessment & 2nd home visitor
		2	Initial Assessment

Parents should be provided initial resources that can eventually be used to solve their own problems. In California, this included videotapes and books on child development and parenting sent by the State. Other useful resources (if they are not available in the home) are local Yellow Pages, pamphlets available on local services available to all parents, information on night school classes at local schools, information on local libraries and what is available (e.g., connection to the internet). If parents only speak Spanish (or some language other than English), information should be provided in their own language. One of the first tasks of a home visitor is to find out what information is available in the family's local community.

Date Completed	Level/Mo.	Week	Task
_____		3	Phone call
_____		4	Consent to Kempe (Family Stress Checklist – see Bugental et al., 2002) Complete Kempe questionaire
_____	1/2	5	Phone call
_____		6	Home visit*
_____		7	Phone call
_____		8	Home visit*

______	1/3	9	Phone call
______		10	Home visit*
______		11	Phone call
______		12	Home visit*
______	1/4	13	Phone call
______		15	Home visit*
______	2/5	17	Phone call
______		19	Home visit*
______	2/6	21	Phone call
______		23	Home visit*
______	2/7	25	Phone call
______		27	Home visit*
______	2/8	29	
______		30	Phone call
______	3/9	33	
______		34	Home visit*
______	3/10	37	
______		38	Phone call
______		40	
______	3/11	41	

_____		42	Home visit*
_____	3/12	45	Phone call
_____		50	1 Year Assessment Part 1
_____		51	1 Year Assessment Part 2
			(Measures taken at the one year assessment will depend on the goals of the program. See Bugental et al., 2002, for a list of the measures we employed)

4. **Progress Notes**

a. Make notes on problem and possible resolution:

What issue did the caregiver identify to work on? (or continue to work on from last visit)

____

____

____

____

What was stated as the cause of the problem? What cues did the caregiver use in deciding that this was the cause?

____

____

____

____

What will the caregiver try as a possible resolution?

____

____

____What cues from the infant will the caregiver be watching for?

____

____

____

____

b. Make notes on resolution of past problem:

Did the caregiver identify a past problem that he/she now believes is resolved (or headway is being made on a resolution)?

____

____

____

____

What did the caregiver decide was the cause of the problem?

____

____

____

____

How was the problem resolved?

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____

What cues to a child's positive emotions (e.g., happiness, interest, peacefulness) did the caregiver report in resolving the problem?

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____

What cues to a child's negative emotions (e.g., fears, frustration, distress) did the caregiver report in resolving the problem?

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____

____

____

c. **Keep progress notes**

Home visitor keeps notes on problem-solving issues in their own case records. They make a copy of their notes and bring them to their weekly meeting with supervisor. They leave a copy of their notes with the supervisor -- who will keep them in her/her files. Home visitors should recheck their own notes before their visit with each family.