

Facilitating a Therapeutic Environment: Creating a Therapeutic Community Using a “Wraparound” Intervention Program With At-Risk Families

The Family Journal: Counseling and Therapy for Couples and Families
2018, Vol. 26(3) 293-299
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DOI: 10.1177/1066480718795121
journals.sagepub.com/home/tfj



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Abstract

This article will focus on how the wraparound model of intervention was applied to a treatment program for children and families at risk. The program was naturally developed during a decade of therapeutic work with families in the Center for Children and Parents in Sderot, Israel. This article illustrates the theoretical assumptions underlying the critical principle on which the wraparound intervention is based and its application to the idea of the therapeutic community as a “facilitating environment.” We will share our experiences as to how the cooperation of a therapeutic community acts as a role model and contributes to the healing of at-risk families and preventing out-of-home placement. Practical issues related to the difficulties in developing a therapeutic community, and also several “best practice strategies” for establishing a therapeutic community as a facilitating environment, will be described.

Keywords

family therapy, wraparound intervention, at-risk families, family-systems intervention, multiprofessional team

Placing children in out-of-home settings is a momentous decision and traumatic event for both the child and his or her family (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). Recently, a growing body of research evidence raises questions about the effectiveness of out-of-home placement (Courtney, 2000; Doyle, 2007). These studies indicate that compared to their peer group, children who grew up in out-of-home placements showed lower achievement levels in various areas of their lives such as employment and education (Berger, Bruch, Johnson, James, & Rubin, 2009; Courtney, Dworsky, Lee, & Raap, 2010; Pecora et al., 2006), higher tendency to engage in criminal activities, and other at-risk behaviors (Mason et al., 2003) as well as showing more emotional difficulties (Courtney & Dworsky, 2006). Berger, Bruch, Johnson, James and Rubin (2009) found that in many cases the return of children to their family environment and the community (through visits or permanent return) without any significant family interventions is a leading contributing factor in reinforcing the cycle of “being at risk.”

Since 1980, there has been a marked decline in the number of outside-of-home placements of at-risk children in Israel (Siegle, Benbenishty, & Astor, 2016). This declination can be attributed to the reform of Israeli welfare services and the juvenile court system encouraging finding alternatives within the community for at-risk children so that they can stay with their families (Israeli Ministry of Social Affairs and Social

Services, 2006). This reform resulted in increased budgets for the development of community services while cutting funding for “out-of-home” placements. Despite the policy change and the tendency to favor solutions within the community over out-of-home placement, the percentage of at-risk children in out-of-home placement in Israel is still higher than in other Western countries (Siegle et al., 2016).

The high number of children and youth who are referred to out-of-home placements is often related to two main reasons: The first is the absence of appropriate services and interventional programs in the community, and the second is the lower level of cooperation of the families with the existing interventional programs.

The large workload of social workers and child protection workers in addition to the lack of appropriate services within the community for the treatment of more complex multiproblem families is a well-known obstacle to treatment within the community (Slonim-Nevo & Lander, 2004). Decision makers

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often prefer resorting to the solution of out-of-home placement for at-risk children as a way of protecting the child as well as alleviating the burden of responsibility placed on them and the parents (Siegle et al., 2016). As a result, the social services operate under the assumption that the solutions available in the community do not provide adequate protection for at-risk children (Slonim-Nevo & Lander, 2004).

Social workers often feel frustrated by the tendency of high-risk families to resist available solutions within the community because they want to avoid cooperation with social services due to the negative connotations it has for them. "Cooperation" is very crucial in that it is one of the major influencing factors when deciding on out-of-home placement as an option. When a parent is perceived as cooperating with the welfare authorities, there is more of a tendency to see the parent as being able to provide his or her children with what they need (Davidson-Arad, 2001). Therefore, it seems that before suggesting any community care program it is essential to understand this resistance.

There are many reasons for the lack of cooperation. We would like to focus on two main factors. The first relates to differences in interpretations of the problem and the intervention goals. In many cases of parental neglect, there is a "clash" between the perception of the parents and the perception of social services as to what defines a "good parent." Parents often feel that loving their children is enough and "doing the best they can" qualifies them as good parents. This is especially true in cases where there is no purposeful intent to harm their children. The conflict between the parents and the welfare worker often raises ethical questions about the limits of the authority and the degree of involvement of welfare workers in a family's life (Slonim-Nevo & Lander, 2004). This situation can potentially create an ongoing conflict around cultural perspectives, values, and ideas about parenting and directly interferes with the possibility of building cooperation and a productive working relationship between the parents and the welfare department.

The second factor that inhibits cooperation is the ability to create mutual trust. Trust develops out of an ongoing process of cooperation between the social worker and the parents. There is a delicate ongoing interaction between these two elements in the relationship between the parents and the social worker. Sometimes, the social worker who is entrusted with the welfare of the child may have difficulty in respecting the point of view of the parents. The worker may perhaps perceive the parents as neglectful and endangering their children which evokes "rescue fantasies" which lead to a desire to rescue the children from their "harmful" parents. Parents, in turn, can experience the social worker as having the power to harm them by removing their children from home (Pecora et al., 2014).

Unconscious processes often influence the contact between the parents and welfare authorities and prevent the possibility of the social welfare team in providing the "holding" function for the "family at risk." Some parents had experiences with the welfare department as children, and as a result, they see themselves as continuing to be victimized by the system. The parents' experience of powerlessness and inferiority is increased in cases of economic dependence on the welfare system in that

the welfare services are experienced as being powerful and aggressive (Pecora et al., 2014). According to P. Walker (2013), many abusive and neglectful parents fit the diagnosis of complex post-traumatic stress disorder (CPTSD) as a result of unprocessed childhood traumas that have occurred and affected the process of their development as parents. In cases of CPTSD, certain stimuli can trigger traumatic reactions (anger and aggression) and "emotional flashbacks" to seemingly benign situations. For example, there may be a heightened sensitivity to the tone of voice used as well as the quality and quantity of eye contact. These reactions, for example, may occur in a formal therapeutic team meeting when the parenting problems are discussed and evaluated. This might be an unbearable situation which can arouse old childhood feelings of being belittled and rejected. The responses of the parents can be perceived by the professional staff as further validating the idea that the parents are inadequate and abusive. In most cases, the parent is unaware of how his or her reactions are the result of his or her childhood traumas. As a result, his or her feelings are perceived as being directly related to his or her current experience. In most cases, the professional workers also do not link these reactions to CPSTD. A vicious cycle can be created by the process that the more the parents feel belittled their responses will be perceived as abusive. This negative cycle may escalate in cases where the parents and the welfare staff become engaged in an emotional storm which includes splitting and projective identification. These power struggles increase distrust and prevent the possibility of cooperation taking place (Pecora et al., 2014; Slonim-Nevo & Lander, 2004).

It is important to be aware of the potential factors that can interfere with the family's ability to benefit from the community care program. Since these factors are sometimes unconscious, there needs to be a constant ongoing self-evaluation process of the professional team as opposed to defining the parents as uncooperative ("be aware" as opposed to "beware").

Community Care Programs

Many intervention programs have been developed for at-risk children who remain in the community. Many of them are based on the wraparound concept, which is a systemic approach, which includes adapting solutions to the particular needs of the family, relying on a variety of services in the community, as well as addressing the various contexts in which the child lives and belongs (Malysiak, 1998; VanDenBerg, Bruns, & Burchard, 2003). As a result of the fact that these programs are tailor-made to fit each, family, and community, a variety of programs were developed.

The evidence from various Western countries indicates that the involvement of the family and the child in the process of intervention contributes to the success of the therapeutic goals and strengthens a sense of optimism, a sense of control, social support, and the ability to cope (Walker & Schutte, 2005). Wraparound programs with at-risk youth showed a decline in behavior problems and crime as well as an improvement of overall school functioning (Browne, Puente-Duran, Shlonsky,

Thabane, & Verticchio, 2014; Bruns et al., 2010; Suter & Bruns, 2009; Walker, 2006).

However, Walter and Petr (2011) argue that more knowledge is needed about “best practice strategies” for wraparound interventions and their effectiveness. This article aims to shed light on a central component of wraparound intervention: creating a therapeutic community of a multiprofessional team. We suggest theoretical concepts and practical strategies that describe how an effective therapeutic community can contribute to the healing of at-risk families.

The Social Context of the Wraparound Intervention

The process of creating a therapeutic community using the wraparound concept as an intervention, as presented in this article, evolved in an ongoing process of trial and error over a period of 14 years of family therapy with many at-risk families from multicultural backgrounds in the Center for Children and Parents in Sderot, Israel. The center in Sderot was established in 2001 by the Israeli Ministry of Social Affairs as a part of a more extensive network of community treatment centers as an intervention that would prevent out-of-home placement. The center in Sderot has its own uniqueness in that the population of Sderot is multicultural and consists mainly of immigrants from various countries. In addition, Sderot is located near the border with Gaza. The year of the founding of the center also marked the beginning of an unstable and stressful period of more than 8 years of wars and barrages of missiles that fell onto the city. Many residents of Sderot began to suffer from PTSD symptoms due to the constant threat of impending attacks and frequent warning sirens (Diamond, Lipsitz, Fajerman, & Rozenblat, 2010). This stress only added to the already existing difficulties of children and at-risk families who were suffering from difficulties related to financial problems and symptoms related to unsuccessful immigration. There were also a high percentage of single-parent families, victims of domestic violence, and families with children with disabilities.

According to the policy established by the Ministry of Social Affairs, high-risk children from ages 5–12 and their families can be referred for a family treatment in the center. As stated earlier, the vision was to create a comprehensive treatment center as a means to avoid automatic consideration for out-of-home placement and to provide family therapy within the community (to learn more about the unique family therapy intervention; see Eisenstein-Naveh, 2001, 2003). The treatment took into consideration each family’s needs as well as the creation of cooperation between services within the community and included the establishment of a multiprofessional and interdisciplinary team consisting of the social worker of the family, the family therapists, school staff (e.g., teacher, school psychologist), and staff from various after school programs. Ideally, the cooperation established between community staff from the different services became the “therapeutic community” which laid the groundwork for creating the facilitating environment.

From Therapeutic Community to Facilitating Environment

Systemic teamwork among professionals is one of the crucial principles of the wraparound approach. Working together is described as a whole greater than the sum of its parts, which allows both caregivers and patients to deal more efficiently with dilemmas (Malysiak, 1998; Walker, 2006).

Systems that cooperate as a therapeutic community provide a similar function of the “good enough mother” that can afford the holding function for the at-risk family. According to Winnicott (1979), the mother’s adaptation to the infant’s needs provides him with the experience of omnipotence. This experience creates the illusion necessary for healthy development. As Winnicott states:

The environment does not make the infant grow, nor does it determine the direction of growth. The environment, when good enough, facilitates the maturational process. For this to happen, the environmental provision in an extremely subtle manner adapts itself to the changing needs arising out of the fact of maturation. Such subtle adaptation to changing needs can only be given by a person and one who has for the time being no other preoccupation, and who is “identified with the infant” so that the infant’s needs are sense and met, as by a natural process. (p. 223)

Parallel processes may occur whereby the therapeutic community creates a support system for the team members. As a result, the professional team members are then able to provide this support to the parents, and as a result, the parents who experience the positive role models can improve their parenting skills to the point where out-of-home placement is no longer considered as an option. Estes (1993) states that:

If the culture is a healer, the families learn how to heal. They will struggle less, be more reparative, far less wounding, far more graceful and loving. (p. 68)

Therefore, a facilitating environment of teamwork is created whereby the professional team feels supported and the necessary holding needed to treat at-risk families. As a result, there is less anger on the part of professionals which often impacts their decisions about the family.

Although the cooperation within a multidiscipline professional team is essential to the success of the wraparound intervention, it is often considered to be an immense challenge (Walker & Schutte, 2005). We learned from our experience that issues that arose within the professional team could mirror the family’s chaos and ongoing conflicts. This is especially relevant in families where the children were considered to be at serious risk because these cases raised the anxiety levels of the professionals in the therapeutic team. Disagreements occurred about roles, and how decisions were made. Often negative emotions of anger, frustration, and helplessness were exchanged as well as mutual criticism about the therapeutic process. This experience was described by one of the family therapists:

Everyone wanted to see immediate improvement in the “problem child”: the school, the court, the welfare department as well as the parents who felt helpless. These messages were communicated either overtly or covertly, and this created pressure on the child and me as well as on the family.

Walter and Petr (2011) argue that one of the crucial steps in reaching the goal of effective teamwork is defining roles and tasks of those involved in the therapeutic process. Assigning roles and functions is necessary in order to avoid chaos, duplication of roles and services, as well as competition among the team members. The therapeutic community is not hierarchical. Each participant contributes his or her knowledge and viewpoint, and therefore a more holistic approach needs to be created which in many ways mirrors the multifunctions and input of family members (Bloom, 2014).

We found that the primary key in establishing effective teamwork is in creating clear boundaries, as well as defining clear roles between those who assess the risk level of the children (e.g., social worker, Child Protection Officer (CPO)) and those professionals who are directly involved in the therapeutic intervention (e.g., family therapist, school psychologist). In other words, it needs to be made very clear to the parents who have the ultimate authority to evaluate their functioning.

The role of welfare department is to assess parental functioning and to evaluate the level of risk of the children. The monitoring of the therapeutic process by the welfare department is done through ongoing contact with the family therapists. This is often done in joint meetings with the family, family therapists, and the social worker of the family. The social worker usually receives progress of the child behaviorally and academically from the school counselor or psychologist. In addition, the welfare department is responsible in assisting the family in reducing economic hardships and searching for additional programs that can enhance family functioning or quality of life (employment training opportunities, after-school programs). The role of the family therapist is not to evaluate or judge the family. It is not the responsibility of the therapist to get involved in material/financial support in order to avoid creating a dependency which could easily sabotage the therapeutic aspects of the therapy. Another essential role of the family therapist is to initiate ongoing contact with those involved with the child and the parents. It is necessary to create an infrastructure of feedback with professionals working with the children. Often the symptoms that the children show in school do not disappear as fast as the school would like. The more the school staff develops empathy for the parents by seeing their motivation for change they are less judgmental and become more supportive of the parents. In some ways, a parallel process is created whereby both parents and school staff feel supported by the therapist, and as a result, there is less blaming and more cooperation.

The role of the family therapist within the context of therapy is to create a therapeutic alliance and trust with the family, based on respect and empathy for the parents’ point of view. The family therapist needs to be sensitive not to use any

authority that could undermine the parents’ sense of being able to make their own decisions. This is a very subtle dilemma that often exists with families that have lost their sense of freedom due to the monitoring of their parental abilities.

The classic psychoanalytic literature provides a theoretical basis for the proposed distinction between the role of the welfare department and the role of the family therapist. According to many writers (e.g., Davids, 2002; Wisdom, 1976), there is an essential distinction between the function of maternal and paternal roles. Both the maternal and paternal functions are crucial and complete the developmental process of growth. The good enough mother gives unconditional love which prepares the child for the conditional love of the father, which symbolizes conditional love which is tied to the restrictions and laws of reality (Davids, 2002; Wisdom, 1976).

These theoretical assumptions can be applied to the multi-professional team approach in treating at-risk families. The therapist constitutes a corrective experience of the unconditional love of the mother and enables the child to prepare for the conditional love of the father which is represented by the welfare department and the child protective services.

It is essential to understand that both roles are necessary for emotional development and there exists a mutual interdependence between them. Without a corrective experience of unconditional love, the meeting of the parent with the rules as well as the demands of reality presented by the welfare authorities is likely to revive the initial trauma of their childhood (Walker, 2013). If the parents fail in dealing with the rules and expectations made on them by society (school, welfare), they can regress and withdraw into a symbiotic relationship with the therapist and not fulfill their duties and obligations (Greenspan, 1982).

However, the trust that evolves between the family and the family therapist can potentially create a situation whereby the therapist is exposed to the various difficulties and vulnerabilities of the parents that they do not openly share and admit to with the welfare department. Ethical dilemmas may arise whether this information can be used to formulate decisions about family. In cases where there are neglect and abuse, it is difficult to draw a clear boundary between clinically evaluating the situation and judging the situation. In many ways, the family and the family therapist are in “a catch 22 situation” whereby it is necessary to expose the risk factors to heal them, and at the same time, this is the crucial information that can undermine the therapeutic process. To avoid a situation whereby the therapist feels trapped within this ethical dilemma, a clear contract between the therapist, the family, and the social worker needs to be created where this issue is discussed and agreed. Clear boundaries need to be defined as to when information that endangers the well-being of the child needs to be reported to the welfare worker as well as taking into consideration issues of safeguarding the confidentiality of the “clients.”

An additional critical reason to define the boundaries between the roles of the professional team is the tendency of families that are considered to be at “high risk” to lack emotional differentiation and as a result, they easily “suck in” the

professionals who may also lack clear boundaries, into their dynamics. In these cases, we can see parallel processes that occur between family members and those involved in treating the family. The relationship will be characterized by coalitions, overidentification, blurred boundaries, and chaos as well as being overwhelmed with feelings of aggression, despair, and depression (Minuchin, 1991). Sometimes, we notice that the complex and conflict-ridden relationships among the therapeutic staff stem from the family's dynamics of splitting between the "bad guys" (the professionals who are in charge of parental monitoring functioning) and the "good guys" (the family therapist who is supportive emotionally).

Klein (1948) addresses the concept of rigid splitting between the "good object" and the "bad object." According to Klein, the schizoid split is an early stage of development in which the baby is unable to distinguish between fantasy and reality and feels that his or her feelings and his or her fantasies make an actual impact on the situation or reality. When the child loves, he or she protects and strengthens the beloved object, and when the child hates, it is destructive and dangerous to its environment. The child feels omnipotent toward its environment. At this stage of development, the ability to accept that the mother is both the source of hunger and satiety is intolerable, and therefore the "splitting" of the bad and good mother is used to soothe the frustration that is created.

In our work, we have experienced how the projective identification process of splitting makes a powerful impact on the cooperative effort of both social workers and the family therapists. An example would be a family therapist who wants to be perceived as "good" and ignores information such as abusive behavior that needs to be reported by law to the welfare department. This reinforces the split by creating a covert coalition with the family by not reporting this information to the "bad" guys, in this case, the welfare department. Another example is when the family therapist also perceives the social worker as withholding resources or being too harshly judgmental.

On the other hand, a social worker who wants to be released from the "bad guy" role might express criticism toward the family therapist either overtly when in joint meetings or covertly when she or he meets with the family.

The members of the professional team need to be aware that both roles are required: The maternal figure that nurtures and contains as well as the paternal figure that confronts makes demands as well as creates frustrating ones. By understanding these complexities, the therapeutic team can prepare itself to deal with these issues as a given as opposed to experiencing fragmentation through rescue fantasies or competitive feelings. The team becomes a positive role model of how complicated feelings can be integrated as opposed to being expressed in a way where the families are perceived to be inadequate or harmful to their children. This awareness, as well as direct communication and mutual respect, is necessary to heal the family as it enables a healthy developmental process to occur in order to deal with the demands of reality without feelings of being persecuted and neglected.

Before concluding, we would like to illuminate the importance of the therapeutic contract.

Creating a Therapeutic Contract

A therapeutic contract needs to be created between the social worker, the family therapist, and the parents. The agreement requires including a precise definition of roles as well as defining mutual expectations with the purpose of working out the difficulties described above. The contract needs to include the following aspects:

- A. The family court, as well as the welfare department, needs to allow the family to go through a rehabilitation process without the interference of any legal procedures. In cases where there is already a legal procedure in process, all decisions involving removal of the children from home need to be placed on hold during the period of the therapy in order to allow treatment to occur without a looming threat. The family is made aware that if there are new reports of child abuse or neglect during this period these need to be reported according to the law.
- B. A specific period is established in order to evaluate the progress of the therapy and its impact on change. During this time frame, more informal meetings are held with other professionals (e.g., from school) as well as periodic contact with the social worker.
- C. Clear criteria that are defined that will evaluate whether the children continue to be at risk. The requirements need to be concrete and documented (e.g., school attendances measured by how many absences are allowed, following through on medical treatment, regular meetings with the family therapist). It is essential that the criteria be realistic enough for the parents to follow through on. For example, you cannot require parents, as part of the contract, to influence academic functioning or the mental condition of the child. It is also important that parents will perceive the criteria as relevant to the best interests of their child/children. Reasonable requirements could reduce fantasies of persecution, feelings of victimization, and a sense of helplessness of the parents. The purpose of setting the criteria also gives the parents a way of doing a self-assessment of their abilities to parent and therefore enables them to make choices about whether they can provide adequately for their children.
- D. Family therapy is offered to the family as a means of helping parents improve their ability to parent and nurture in order to prevent out-of-home placement. It needs to be emphasized that the family therapy is not a tool to do a formal evaluation of parental competence. It needs to be made clear to the family that there are specialists who are trained to do this and they will be referred to the welfare department if required.

- E. A clear boundary needs to be made explicit to the family about the difference between the roles of welfare department (social worker, child protection officer) and the family therapists' role. To go through a process of change, the family needs to develop enough trust in the therapists to share difficulties and vulnerabilities without feeling a potential violation of their privacy. The parents will first review all information that will be shared and they have the option of excluding information except in cases where the child is considered to be at risk by definition of the law. The parents must also be made aware of the fact that nonattendance of the therapy will also be reported.

Various strategies can be used to clarify the goals of treatment during the first meeting between the family and the therapeutic team. A recommended procedure is that the family therapist raises various questions to the welfare worker in the presence of the family. That is why are you referring the family to therapy? What are your expectations? How will you know that the expectations are fulfilled? What are the changes that you would like to see in the family? How do you expect the mother/father to function differently at the end of the treatment? What will happen to the family if there is no change? These questions make it possible to refine the criteria for success by making them concrete and clear to both the family and the professional staff. Even during the treatment, in situations where therapeutic goals and sanctions need to be reinforced, one can reintroduce the presence of the social worker through placing an empty chair in the room and ask the parents what they think the position of the social worker would be in certain situations. In this way, the role of the family therapist is protected, and the parents need to take responsibility for understanding the consequences of their behavior.

For example, in a single parent family, the mother was not able to function as an authority figure for her teenage daughter. The daughter was often truant from school, would hang out with older boys and was also suspected of drug abuse and being sexually exploited. In the first meeting of the therapeutic team, the family therapy was introduced by the social worker as the last opportunity before considering out-of-home placement. The therapist turned to the mother and said, "The welfare department threatens to remove your daughter from the home if there is no improvement in her self-harming behavior. Consult with your daughter and decide what the two of you would like to do with this possibility. Maybe you can convince the social worker not to use out-of-home placement as a solution. Ask the social worker if there are other options to help your daughter without taking her out of the home. (Domani, verbally quoted 2012)

In many cases, we found that the contract is crucial as the first step in building the trust of parents in the family therapist and enables a better start in the family therapy process.

For example: In the first meeting held with the family, the parents came with their three children. At the beginning of the session, the

children refused to talk and answer questions posed by the therapist. They were still and avoided eye contact with the therapist. After several minutes of silence, the father told them, "it's okay. You can talk to her. She told the welfare authorities that she would not share any information from our sessions unless we see it first. I trust her. You can talk." After the children received approval from the father, they were willing to cooperate.

To conclude, in this article, we tried to share several insights and therapeutic strategies that were formulated in a process of trial and error in the treatment of many at-risk families. The approach's primary objective is to give families a new loving experience. Feeling "lovable" leads to being "love able." Our main goal was to emphasize the important role of the therapeutic community as a facilitating environment in order to achieve a sense of feeling loved. We show how wraparound interventions give families this opportunity by acknowledging that to successfully provide this experience the therapeutic community must itself embody this experience. In the same way, one discusses in individual therapy the corrective experience as the therapeutic process that heals, it is also relevant when the therapeutic community provides this as an experience. In an interview with Oprah Winfrey in 2009, Maya Angelou said: "I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel." It is important to remember that even though no intervention can offer "magical solutions" for out-of-home placement, supplying the family a facilitating environment has a significant impact and effectiveness in the family rehabilitation process.

Authors' Note

Parts of this article were originally included and published in Hebrew in the electronic journal: Hebrew Psychology. www.hebpsy.net 9/4/17 and Mifgash. Journal of Social-Educational Work. Vol. 24, no.43. June 2016. "A Model of family-system intervention for high risk families."

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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