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How to Work with Complex Families in Regional Tasmania: Putting Theory into Practice

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This paper explores the complexities of how to get our families who are often in a chaotic state of surviving (emotionally, psychologically, and physiologically) to the point where they can process psychoeducation, develop parenting skills, and implement strategies to care for children in enduring ways and to feel successful in their everyday lives. This exploration led us to ponder two questions:

1. What are "good" working relationships?
2. How do these relationships benefit the families we work with?

To explore these questions further, we turn to a fuller body of research on Attachment Theory and Polyvagal Theory that gives a better understanding and comprehension of incorporating these theories into practice. This paper attempts to illustrate how the workers in the North-West Early Start Therapeutic Support programme delivered by Anglicare Tasmania develop good working relationships with families and how this translates to providing enduring care for their children.

■ **Keywords:** complex families, attachment, felt safety, trauma

North-West Early Start Therapeutic Support (NESTS) provides support to complex families "at risk" and on the verge of involvement with Child Protection Services (CPS) on the North-West Coast of Tasmania. The North-West Coast of Tasmania is a regionally large geographical area covering 20,826 km^2 (Australian Electrol Commission, 2016), incorporating many small towns and several cities. The North West has a population of 113,834 people as at 30th June 2015 (Tamanaina Government – Economic Analysis Unit, 2016). Statistics from 2011 identify that there were 88 per 1000 children under the age of 5, including unborn babies, notified to CPS (Kids Come First - Department of Health and Human Services, 2011). NESTS is funded by the Tasmanian Department of Health and Human Services to provide intensive therapeutic support to families who have come into contact, or are at risk of coming into contact, with CPS. Generally, between 70% and 80% of NESTS caseloads are families who have some current or historical involvement with CPS.

Typically, we would consider complex families to be families who present with multiple systemic barriers including intergenerational poverty, poor housing conditions, poor educational attainment, and unemployment. These issues can be further compounded by poor health and emotional wellbeing; drug and alcohol misuse; incarceration of a family member; and domestic violence. Commonly, NESTS parents have a high adverse childhood experiences (ACEs) score, an assessment that identifies cumulative childhood stress in the domains of abuse, neglect, and family/household challenges (Center for Disease Control and Prevention, 2016). Extensive research on ACEs identifies a direct relationship between ACEs and negative health and well-being across the life span. Some of the increased risk factors include poor educational attainment, illicit drug use, partner violence, teen pregnancy, depression, and alcoholism, to name a few.

The funding of the NESTS programme aims to improve developmental outcomes for children measured by

1. improved bonding and attachment between the infant and the parent/carer(s);
2. improved children's wellbeing and safety;
3. reduced family risk factors and/or reduced impact of risk factors;

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4. improved awareness and use of the universal and secondary services available for themselves and their children by parents/carers; and
5. participating families are supported to care for children in enduring ways that prevent notification and renotification to statutory systems.

There is a litany of wonderful evidence-based programmes that use trauma and attachment informed frameworks to develop parent's awareness of children's emotional, social, physical, and cognitive developmental needs as well as providing positive parenting strategies and developing parenting skills. NESTS eclectic toolbox of trauma and attachment focused programmes include but are not limited to the following:

1. Bringing up Great Kids®
2. Tuning into Kids®
3. Trust Based Relational Intervention® TBRI®
4. Theraplay®

NESTS utilise these programmes in one form or another in the work that we do with families. In the experience of working in NESTS, these programmes work well with parents who are at that stage in their journey where they are able to process the psychoeducation, develop parenting skills, and implement the strategies that have been taught and modelled in their day-to-day lives. However, very rarely does a family come into NESTS who are at that stage in their journey where they are ready to undertake this kind of work. Typically, NESTS families present with multiple systemic stressors that manifests at varying intensity on any given day. This needs to be recognised and honoured.

Due to the advances made in neurobiology during the 1990s, the "decade of the brain" (Schore & Schore, 2008), we know stress has a significant impact on the physiological function of the brain that affects an individual's ability to regulate bodily functions and mediate cognitive processes. Daily stressors can mean the difference between surviving and thriving for our families. For example, one NESTS mother felt she had no control. She used the analogy of feeling as though she was flowing along with the current of a river, continually treading water, head barely breaching the surface. Generally speaking she managed, but she never really felt that she had the ability to swim to the shore to pull herself up on to the river bank and rest. Just like a river, her life was unpredictable. Daily life stressors would come flooding in just like flood waters after a storm and become all too much for her, she would describe the feeling of her head going under, unable to breath, the feeling that she was drowning. To further complicate things, the river was pocketed with log jams along the way, created by the storm water waiting, just like the systemic barriers which she had no control over.

So this leads to the question of how do we get our families from this often chaotic state of surviving (emotionally, psychologically, and physiologically) to the point where they can process the psychoeducation, develop the parenting skills, and implement the strategies to care for children in enduring ways and to feel successful in their everyday lives?

NESTS is a programme that has been driven by a process of action research over the past five years. The focus on attachment for the programme was a requirement of the funding body and our interest in trauma informed practice was influenced by the embodied histories of ACEs that came with our families. However, NESTS staff were driven to further explore the current research on working with highly complex, hard to engage families "at risk". There has been lots of research done in Australia and overseas that has examined this area. One reoccurring theme in this research is that relationships are a key contributing factor for building resilience and overcoming adversity. We need to develop positive relationships with our parents so the embodied experience can be transferred to the relationship with their children. Although this is useful to know and confirms what we instinctually know to be true, we still did not feel that this was very clear and it did not give us anything tangible with which we can work.

Our practice experience then led us to pose two questions:

1. What are "good" working relationships?
2. How do these relationships benefit the families we work with?

What Current Research Tells us About Working with Families with Complex Issues

Working with families who experience complex issues is challenging for both the families and service providers who support them (Reimer, 2014). First, we know from research that families who are in greatest need often do not seek help until they have reached a crisis point (Butler, McArthur, Thomson, & Winkworth, 2012). Second, research also tells us that once families receive the "band-aid" fix for their crisis they often disengage from services. So how do we successfully engage and support those who use our services in the context of crisis? More importantly, how do we successfully maintain engagement beyond the crisis point to facilitate enduring change? A review of the literature regarding working with complex families suggests that there are a number of ways to work with these families, but all have a reoccurring recommendation—that is, building positive, trusting relationships with clients (Butler et al., 2012; Coates & Howe, 2015; Horwitz & Marshall, 2015; Katz, Spooner, & Valentine, 2006; Preyde, Cameron, Frensch, & Adams, 2011; Reimer, 2014; Watson, 2005). Some studies have shown that the effectiveness of a programme depends highly on the workers'

personal efficacy and characteristics, with some estimates of the importance of the worker being as high as 50–80% (Katz et al., 2006).

Workers who work closely with families who are involved in the CPS or are at risk of being involved with CPS are particularly complex (Horwitz & Marshall, 2015). First, families do not choose to be part of or involved with CPS; it is an involuntary process due to complex issues. There is a significant amount of distrust from client to worker and this produces a major barrier in creating change within these families. Therefore, it is crucial to develop a positive relationship with these families as it helps to build engagement and can support the clients to feel hopeful about the interventions they are required to partake in. The relationship is important in this process as clients feel that their workers genuinely have their best interests at heart.

This is consistent with a study that included 80 in-depth interviews with parents living on income support in two localities in Australia (Butler, McArthur, Thomson, & Winkworth, 2012). These parents highlighted major issues that influenced their health and wellbeing, including financial difficulties, housing stress, parenting, and significant worries about their children's health and wellbeing. The interview was focused on three key elements: the families' use of services; what enabled access use; and barriers to access use. A major theme arising from the positive service experiences was that it involved "an active, caring response to the individual situations of the families, parents, and children" (Butler et al., 2012, pp. 580–581). The families identified that an important aspect of this is the worker standing by them, believing in them, listening, and respecting them. In this study one of the most important factors leading to change was the feeling of being related to as a human being rather than a client. The families expressed their wish to continue working with the worker they had built the positive relationship with, rather than changing to someone new, even when they were referred to a different service due to funding or eligibility requirements.

Another recent study conducted on a pilot programme that was developed in New South Wales called Keep Them Safe-Whole Family Team (KTS-WFT) further adds to the importance of relationships in creating successful engagement and service provision (Coates & Howe, 2015). The aim of the KTS-WFT programme was to improve parenting capacity, child safety, and family functioning along with significantly reducing the level of risk of significant harm to the child/children within these families. The research used qualitative data collected from 20 discharged clients who had completed the 2-year programme, as well as 10 KTS-WFT clinicians who supported the families. The qualitative data were collected by interviews that used broad open-ended questions and began with "*How was your experience with the KTS-WFT service?*" for discharged clients and "*What do you think about this service*" for the clinicians. Little probing was used in order to keep a balance between the research agenda and whatever meanings emerged during the interview process. The main theme that arose from the interviews with the discharged clients was the "relationship with the worker" and the crucial role that played in establishing engagement and facilitating change (Coates & Howe, 2015; Watson, 2005). However, caution has been raised as to the difficulty in defining, quantifying, and empirically testing the worker–family relationship and that establishing trusting relationships "cannot be reduced to a formula of behaviours" (Watson, 2005, p. 8).

From this research, it emerges that relationships are crucial in developing effective engagement and service provision that facilitates positive change in the lives of the families with whom we work. The key themes are building trust, facilitating client openness, being listened to, the feeling of being believed in, and feeling supported. Research findings have indicated to us what is considered to be essential qualities in a good working relationship from a client's perspective, but this research has not explored how to create this working relationship. How can attachment theory help us to create good working relationships?

Using Attachment Theory to Better Understand Relationships

So from this research two themes become apparent. The first theme is "trust"; the concept of a " . . . positive, trusting relationship . . . " and a feeling that workers "have their [clients] best interests at heart"; workers believe in them and respect them. This suggests an intrinsic feeling of trust in the worker. One can argue that trust builds over time and through experience. But if you do not have the time and opportunity to build trust through repeated and patterned positive experiences because our families are hard to engage and service weary, how can trust be created?

The second theme is "relationship with the worker". Research states that the relationship involves concepts like empathy, caring, understanding, openness, listening, and " . . . feeling related to as a human being rather than a client" (client comment). This suggests something more than the mere provision of a service. This suggests an interpersonal experience of relational exchange that is more significant and meaningful, which can facilitate families to care for their children in enduring ways. So, how can meaningful relationships be created?

To explore these questions further we turn to a fuller body of research on attachment theory. Attachment theory has been bolstered by the "decade of the brain" in which much neurological understanding has been gained (Schore & Schore, 2008). This has developed an appreciation for the interdependence of attachment relationships and the neurological development of an infant's brain (Schore & Schore, 2008). Siegel (2015), in his exploration of interpersonal neurobiology of attachment, describes attachment as an interpersonal relationship between infant and care giver in which "the immature brain uses the mature functions of

the parent's brain to organise its own process" (p. 91). Essentially, what this means is that when an infant comes into the world, the infant's underdeveloped brain is incapable of growing and organising by itself; it requires an another to help the brain to organise and regulate, creating a process for psychobiological development.

Attachment behaviour is based on an underlying need for the feeling of safety and a secure base in which to grow and develop (Schore & Schore, 2008). In the crucial formative early years of life, this interpersonal attachment relationship creates a foundational template of behaviour patterns determined by the infant's "felt" experience of safety or non-safety. This "felt" experience of safety or non-safety also influences the developing child's confidence in exploring the world. During this exploration or non-exploration of the world, the developing child is making sense and creating meaning about what the world means to them and their position in this world. This is what Bowlby identifies as the Internal Working Model (IWM) (Siegel, 2015).

So there are two key points here that we feel needs to be explicitly stated.

The first is the experience of safety. For survival, infants need someone else (the primary care-giver) to keep them safe by meeting their needs. When infants are hungry someone needs to feed them; when infants are cold someone needs to keep them warm; when infants are scared someone needs to reassure them that nothing can harm them. The explicit meeting of these needs creates an experience of physical and emotional safety. In addition to this experience of 'felt' physical and emotional safety there is also a simultaneous, implicit, non-conscious process occurring in the body; a physiological experience. With every interaction between a primary caregiver and the infant (if it is a positive and attuned interaction) the 'mature brain' is regulating the 'immature brain' through the creation of neuronal pathways. Through predictable and patterned responses neuronal pathways are created which facilitates a process to develop a greater capacity for physiological self-regulation throughout the development of the life span.

The second point is how an infant's interpersonal experience with their primary caregiver, positive or not so positive, influences the way they perceive the world creating a mental map or IWM (Becker-Weidman, Ehrmann, & LeBow, 2012). For example, because I have someone who can meet my physical, social, and emotional needs, others can also meet my needs. From this early childhood experience, it is inferred that people are safe, people can be trusted, the world is safe, and therefore, it is safe for me to interact with the world. If I do not have someone who can meet my needs, meet them only some of the time, or meet my physical needs but not my social and emotional needs, I would have a very different IWM of the world. I would interpret people and the world as being hostile and unsafe; or people as unpredictable and the world as confusing. My IWM significantly influences the way that I interact with others and the world.

The IWM also provides a template of how infants and children come to understand themselves. As an infant, if you have a primary caregiver who is attuned and responsive to your needs you learn that your needs matter and you are worthy. If you have a significant other who looks at you with love and joy in their eyes and a smile on their face, you soon learn that you are a joy and pleasure to be around, you are worthy of love. This is what is called a positive IWM. If on the other hand, you have a primary caregiver who is unresponsive or unpredictable in meeting your needs, you learn that your needs do not matter or they only matter under certain conditions. If this significant other looks at you with a lack of emotion or warmth, or with negative facial expression such as frowns or scowls, or display anger or aggression, you soon learn that you are not a joy to be around, you are unworthy of love. This is what is called a negative IWM. This process is called primary inter-subjectivity and Ed Tronick in his "Still Face Experiment" (Tronick, 2009) provides a visual example of this interpersonal interaction between infant and mother.

What do Attachment Relationships (Secure or Insecure) Tell us About the Developing Child?

As infants develop into childhood, they are also developing the skills they need for self-regulation when faced with distress and adversity, a form of resilience. Simultaneously, they are creating meaning about themselves, their relationships with others, and their relationship with the world. All of this is dependent on their interpersonal relationship with their primary caregiver. Although we have provided a brief overview of attachment theory, we cannot overemphasise the profound effect attachment relationships have on psychological, social, emotional, and physiological development of an individual.

If the attachment has been secure they gain competence in developing self-regulation, they see themselves as worthy, lovable, and good. They also see the world as safe, people are safe, and relationships are safe. If the attachment is classed as insecure, their ability for self-regulation is underdeveloped, and they view themselves as incapable, unworthy, and bad. They also view the world, people, and relationships as unpredictable, untrustworthy and/or unsafe. This is demonstrated in a longitudinal study that confirmed and explicitly identified what Bowlby had hypothesised; those infants with a secure attachment will develop a greater capacity for self-reliance, emotional regulation, and social competence (Sroufe, 2005). These individuals also have well-developed physiological regulation (Schore & Schore, 2008).

This longitudinal study (Sroufe, 2005) identified that school-age children who have secure attachments/self-regulation skills have high levels of positive peer interaction, a great deal more social and emotional competence, and they presented with persistence, flexibility, and

adaptiveness to situations. These children also demonstrated a greater ability to remain on task in the class room, with a greater capacity for focus and attention during structured class room activities and high levels of problem solving skills. Children with secure attachments are more self-confident, with higher levels of self-efficacy and ego resilience. The study also found that those identified as having insecure attachments demonstrated a lack of persistence in the face of a challenge, underdeveloped, and often rigid problem solving skills and demonstrated high degree of frustration and anger when faced with a challenge. Those with insecure attachments also presented as lacking in self-confidence, had low levels of self-efficacy, and low ego resilience.

Although this study identified that those with secure attachment were able to navigate through the life span experiencing more positive life outcomes, it does not mean that people are immune to an ACE. It does, however, mean that they are more resilient to the negative effects of cumulative childhood stress. In contrast, those with underdeveloped self-regulation capacity, low levels of self-efficacy, and low ego resilience are more susceptible to the negative effects of cumulative childhood stress that is brought about by ACEs.

So what does all this mean for our complex families in NESTS? We have identified that the families we work with have low skill levels for regulating stress and resilience. We have also demonstrated that attachment has been identified as a way to develop skills for self-regulation and resilience. As we have demonstrated, this is something that develops through secure interpersonal relationships. Schore and Schore (2008) argue that "therapeutic interventions are rooted in the same dynamic relational process [as parent – infant]" (p. 10). "The co-creation of an attachment relationship between the empathetic social worker and client has also been seen as the sine-qua-non of clinical practice" (Schore & Schore, 2008, p. 10). Another way of viewing this is for the worker to become a transitional secure attachment figure for our parents. The explicit relational knowledge can then be transferred from the worker–parent relationship to the parent–infant relationship as a parallel process.

There are two key learnings that we can take away from attachment theory, first, the importance of creating felt safety and, second, becoming a transitional secure attachment figure. So the next question then is *how* do we create felt safety and become transitional secure attachment figures for our families? Given that a majority of our families come into our programme with a negative IWM, already having a template that identifies others as not being able to meet their needs and that others are unsafe, it can be very challenging to support change. However, again, due to the decade of the brain, we know that the brain is plastic; it has the ability to change and add new neuronal pathways. This is what we aim to do for our families, and once that happens, they are then more able and likely to provide that same experience for their own children (Becker-Weidman et al., 2012).

Illustrating the Development of Felt Safety

Felt safety is a physiological experience that sits within the implicit realm of the nervous system. As we have identified, our families have been involved with CPS and, as such, are service weary and often full of mistrust; or if you like "hypervigilant" about who we are as a service and what we do. If we, as workers, can calm the threat response system (fight, flight, and freeze response), then we can create a space for trust to grow. In addition, the concept of felt safety recognises and honours the embodied histories of the people with whom we work.

From here, we draw from the Polyvagal Theory. This is an area of theory that looks at how the nervous system unconsciously detects and responds to the safety cues or lack of safety cues in the environment. This is called "neuroception" (Porges, 2015). If through the process of neuroception safety cues are sensed, defensive systems are dampened and social behaviour is facilitated. If through the process of neuroception danger is sensed, defensive strategies of fight, flight, and freeze are promoted. These safety cues do not have to be directly related to physical safety. The Polyvagal theory describes how feeling safe can emerge from reciprocal interpersonal interactions and this feeling of safety enhances social connectedness. Interpersonal interactions can be verbal and non-verbal. The strongest non-verbal social interactions such as tone and volume of voice, patterns and speed of verbal communication, and eye contact strongly resonate with the early attachment experience.

The quality and experience of these non-verbal cues in early childhood affects the process of neuroception. This, in turn, influences an individual's experience of felt safety at any given time, whether the danger is real or perceived (Schore & Schore, 2008). In other words, to create felt safety is to provide attuned, empathetic, predictable, and patterned responses in order to dampen the threat response and optimise the ability to create trust.

Creating felt safety is really about the implicit interpersonal interactions we have on a day-to-day basis. A crucial element to creating felt safety is recognising that just because you know someone is safe, does not mean that they *feel* safe. A lot of the families that we work with have traumatic backgrounds and often experience incongruity, the body's physiology identifies the environment as dangerous even when it is safe. A common example of this is when a child has experienced sexual abuse that has taken place in their bedroom, and even when the abuser is removed from the environment they still view their bedroom as unsafe. We often misinterpret signs of feeling unsafe as the child "acting out" or "throwing tantrums", perhaps the child is not being "defiant" but their threat response system has been activated and they are fighting for survival. Another common example is when an individual has experienced physical violence and responds with fear (flight/freeze) or even aggression (fight) to your verbal or non-verbal cues,

for example, when you raise your voice and similarly if you raise your arm/fist (non-verbal). Another less obvious example is when someone responds to you with a negative emotion and associated behaviour, fear (disengagement), anger (aggression), or sadness (crying), for what *we* see as no apparent reason. This could be because of non-verbal cues, a facial expression, a rise of the eyebrow, or even just direct eye contact. We know ourselves that these non-verbal cues are not harmful, but perhaps the individual associates direct eye contact with "being in trouble" that leads to them being abused (physically, emotionally, or psychologically).

An example we see often in our work in NESTS is that the feeling of being close to someone is unsafe. Opening up to someone and letting them in is often extremely hard for the people with whom we work, mainly because they have been "burnt" in the past, or it has always led to a negative outcome. We often see that right when someone begins to open up, they often then disengage from the programme. This is a sign of the threat system being activated, and they are choosing "flight". The way we counteract this is by being consistent, and continually showing them that even though they are trying to push us away because they feel unworthy, we are still there for them (predicable and patterned responses). This is allowing them to create new neuronal pathways in the brain that demonstrates other people can meet their needs and, in turn, supports the creation of a positive IWM, i.e., "I am worthy".

This experience has been particularly apparent with one of our NESTS participants, a woman who would open up a little, and then attempt to disengage. After the first couple of times this happened we identified that this was a pattern for her. We put in a plan to support her in which she allowed us to cold call in order to ensure we would have face-to-face time. This happened approximately five times during the first year of working with her. However, by us keeping up our end of the bargain, by following through on our plan, we were able to provide predictable and patterned responses that created a feeling of safety. This supported us to become a transitional secure attachment figure in her life. One NESTS worker describes an appointment with her during which they attended a doctor's appointment together. The client had identified that she was feeling depressed and asked for support in trying anti-depressants. She had previously tried counselling but advised the doctor that it did nothing for her and that she gets more out of talking to her NESTS worker than a counsellor. The doctor asked her a number of questions, in a manner that was very cold, direct, and confronting (lack of empathy). The client looked so uncomfortable, with head down and arms crossed, giving minimal answers and even having the physiological response of a red face (lack of attunement). The NESTS worker stated:

> You could see her threat response activating and she was withdrawing. After the appointment we got in the car and she broke down, she cried and stated that she didn't want to talk to anyone else other than me and that I am the only one she feels comfortable enough to talk to. We returned to her house and she began talking to me about her childhood. She advised she had never talked to anyone about 'that' before. It was at this appointment I knew she felt safe with me, at that point, I knew I had become a secure base for her (Personal Communication, 2016).

Demonstrating the Development of a Transitional Secure Attachment Figure

Creating felt safety is an important component in becoming a transitional secure attachment figure. Once that feeling of safety is established, we really start to create/change the neuronal pathways in the brain. Thinking back to the analogy used by the NESTS participant at the start of this article, it is as if we have offered a helping hand for the person we are supporting to finally make their way to the river bank for some time to rest and reflect. It is here that together we can start thinking and working towards creating resilience. As we know, there are daily stressors and systemic issues that can sometimes pull our families back into the river, but the idea is that they are better able to pull themselves back up onto the river bank when they occur. It is our hope and experience that eventually they no longer need our support and they end up spending more time on the river bank than in the river.

If we look at the work we do in NESTS, there are two key points to identify. The first is that we know from attachment theory and polyvagal theory that learning can only occur if we have established felt safety and disarmed the threat response. The second is that once felt safety has occurred we are then able to further develop our families' abilities to manage everyday life stressors and struggles. This occurs as workers become a transitional secure base for the people with whom they work. This allows for a place to explore and develop emotional regulation, empathy, reflective functioning, and observational skills.

This is where the real work begins. We demonstrate good observational skills by noticing when the people we are supporting are feeling unsafe. We demonstrate reflective functioning by recognising that their behaviour is a result of them feeling unsafe. As mentioned earlier, they do not disengage because they do not want support, they disengage because they are scared. Generally, this is the time when we are needed most so that we can co-regulate their emotions by offering support, comforting them, keeping calm, and adding language to their emotional experiences so that eventually they can self-regulate. Doing this creates a lived and embodied experience for our families that they can then transfer into their day-to-day lives with their children and interpersonal relationships.

Through this parallel process, parents develop the ability to put themselves in their children's shoes. We start to see parent's shifting from "my child is hitting and kicking me because he hates me" to "he is scared and needs me to help

him regulate his feelings". It is here that we know our families are sitting on the riverbank watching the chaos of the river and recognising how this is impacting on their child. It is now that they can become the secure attachment figure for their child/children.

However, for our parents to develop a secure attachment with their children, they need to have had the experience of feeling safe and supported so that they can reach the river bank. We help them to experience this by holding out our hands and helping them up to the river bank. We then sit with them and this becomes their secure base. From here we can work together to find solutions, strategies, and develop resilience so that eventually they are able to sit on the river bank without our support. This is the essence of a transitional secure attachment figure – the hand that helps them up until they no longer need us – they can now pull themselves up on their own.

Conclusion

For NESTS, creating felt safety and becoming a transitional secure attachment figure is the missing link in creating "good" working relationships. It not only benefits our clients, but it also supports us in the work that we do with them. For us as workers, we know that this way of working is beneficial because not only does it increase the ability to support change for our clients, but we are also experiencing a relationship in which it is easier to talk about the "hard things" or discuss areas of concern. We know that the person with whom we work will be able to respond in a more positive and attuned way and see our concerns as "they care about me, and want the best for me" rather than "they think I'm a bad person" or "they are telling lies about me". These conversations are important to have so that our families can support and care for their children in enduring ways. We see that they are improving their capacity for self-regulation, emotional competence, flexibility, and adaptiveness to stress. They are challenging their embedded feelings about their relationships with themselves, the world, and others. However, our complex families will always be dealing with systemic barriers and everyday life stressors, this chaos in our families' lives is unavoidable. Unfortunately, there is no neatness in the work that we do, no tying things up in a pretty little bow in which we can stand back and bask in the glow of the work we do with families. So how do we know that families have benefited from the relationships we have developed with one another? This is where we can take stock of their metaphorical river journey and ask the questions: are they reaching the river bank? Are they spending more time on the river bank being able to rest and reflect? When the flood waters come, are they able to keep their heads above water? And are they able to miss the log jams of systemic barriers along the way? If the answer is "yes" then, as practitioners, this is where peace can be found.

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