

Incorporating family into the formula: family-directed structural therapy for children with serious emotional disturbance

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ABSTRACT

Increasingly, policy-makers and consumers alike have been pushing for inclusion of families in the treatment of children with diagnoses of serious and emotionally disturbed (SED). Further, recent trends in service provision highlight the necessity for creation and utilization of evidence-based practices (EBP), as well as the need for consumer- or family-driven treatment. Although family therapy is a popular intervention for this population, existing evidence-based family therapy modalities fail to incorporate family direction in the treatment of children with SED. Moreover, the models studied have involved juvenile offenders, and, to date, little research has been conducted to substantiate their use with the SED population. Family-directed structural therapy (FDST) is an emerging model that unifies evidence-based practice with family-directed care. This model actively involves parents and family members in the change process blending consumer-based principles with a growing empirical base. In FDST, the family is both the fulcrum of power and source of change in the family. A description of this approach and an exemplar are provided to illustrate application of this model with families of children with SED.

INTRODUCTION

In the USA, nearly 1 in 5 children between the ages of 9 and 17 have a mental health concern that affects their functioning at home or school, or their relationship with friends (US Department of Health and Human Services 1999). Children with mental health problems have a higher incidence of dropping out of school, higher rates of juvenile incarceration, higher rates of hospitalization, and an increased risk of suicide (Kozak & Owings 2003; Corliss *et al.* 2008; US Department of Health and Human Services 2001). Further, mental health needs demand substantial time and emotional commitment from parents and caregivers. While there is mounting evidence that families dealing with mental illness are at increased risk for depression, anxiety, relational problems, financial strain and social isolation, the totality of the impact of mental illness on

family members is difficult to measure and is consequently overlooked (Smith *et al.* 2001; Heflinger & Taylor-Richardson 2004; Corliss *et al.* 2008).

In an attempt to help children and families better access services, in 1993, the Center for Mental Health Services developed guidelines to better define serious mental health problems in children and the definition of serious emotional disturbance (SED) emerged, a term used to indicate a child has a psychiatric diagnosis and an impairment that impacts their family life, school functioning, and/or participation in the community (Duchnowski *et al.* 2002; McLendon 2008). Between 5% and 19% of children in the USA meet the SED diagnostic criteria (US Department of Health and Human Services 1999; Anderson & Mohr 2003). In 2004, approximately 900 000 children with SED received services from their state mental health authority, most being Caucasian (60%), African-

American (25%) and Hispanic (5%) (Substance Abuse and Mental Health Services Administration 2005; McLendon 2008).

The family environment naturally changes over the course of time, thus it makes sense to include parents and families extensively in the SED treatment process. Ultimately, parents, not outside agencies, must raise their children, making their intensive involvement in the treatment process critical. Engaging families in treatment, however, is not an easy task. When families seek assistance, most often it is because they have lost the ability to successfully deal with one or more problems on their own (Marlow & Sauber 1990). Therapists must help the family restore the ability to deal with the problem(s) on their own so that change is sustained when services cease. In reality, therapists will rarely be successful in changing a family's ideological positions on different issues. If the therapist does not join the family where it is, they will likely be met with new intellectual or emotional lines of defence (Marlow & Sauber 1990). A philosophy of consumer-driven or family-driven care assists therapists and other service providers in providing family-centred treatment that understands and respects the family where they are and encourages the family to take the lead in deciding the direction the therapeutic efforts should go. As a result, there is family buy-in at the onset of services where families are invested in change.

Unfortunately, many current therapeutic modalities, particularly family therapy modalities, lack an evidence base that includes consumer-driven therapy. Although EBPs are being developed that more actively involve families in directing the mental health treatment, these programs are not family-centred treatment modalities that encourage the family to take the lead in deciding the direction the therapeutic efforts should go. Family-directed structural therapy (FDST), a promising new approach, has been successful at integrating family-driven care with treatment while showing promising empirical support (McLendon *et al.* 2009). Whereas the originators of FDST provide a conceptual overview of this model in previous publications, this paper takes FDST a step further by comparing it with other popular modalities while suggesting its applicability for filling the gap that exists between evidence-based family therapy models and consumer-driven or family-driven treatment. Moreover, this paper illustrates the functional and structural application of core issues with family members, and highlights the therapeutic components of the model that reinforce consumer-driven change.

UNIFYING EBP WITH FAMILY-DRIVEN TREATMENT

Governmental agencies and consumers of mental health services alike are urging the mental health field to take a more assertive approach in working with families to enhance child services. Recently, the US government acknowledged the importance of family in both the treatment and support of children with SED. In this regard, the July 2003 Final Report of the President's New Freedom Commission on Mental Health (2003), set out this specific recommendation:

local, state, and federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services. The direct participation of consumers and families in developing a range of community-based, recovery-oriented treatment and support services is a priority. (New Freedom Commission on Mental Health 2003, p. 37)

Indeed, recent research indicates that families desire a family-centred mental health services approach, defined as the delivery of consistent and coordinated care that entails structured collaboration between the family and mental health professionals, being respected by mental health professionals, geographic availability of services, and provision of culturally competent care (Spencer & Powell 2000; Kruzich *et al.* 2003; Ditrano & Silverstein 2006; Williams Adams 2006; McLendon 2008).

Mental health professionals are challenged with determining how to effectively treat children with SED and their families, using the best techniques available. However, tension exists between the two primary conceptual ideas about how to provide such treatment: utilization of family-driven or consumer-driven treatments vs. use of prescribed, step-by-step empirically based evidence-based practices (EBPs). For instance, proponents of consumer-driven treatment suggest that obtaining information from the consumer perspective is consistent with the values of the social work profession, specifically, those of empowerment and self-determination (Petr & Walter 2005). Empowerment is a loosely defined term in the literature ranging from a focus on having the resources and the opportunity to play a role in shaping one's environment to a focus on feeling valued, heard, respected, and believing one can affect change (Saleebey 1997; McLendon *et al.* 2005). The proponents of a consumer-driven treatment perspective suggest that the concept of empowerment should be synonymous with consumer care, and that the word 'consumer' implies that clients have a choice in what services they

receive (Salzer 1997). Regardless, across the continuum of definitions, the concept of empowerment assumes the consumer is ultimately driving the change process.

Some researchers question if current practices by service providers are negating vs. promoting empowerment by inherent organizational policies (Salzer 1997). For instance, Salzer *et al.* (1994) argue that most mental health service delivery models buy into 'professional-centrism', where it is thought that the more professional skill that is used is directly related to the more clients will benefit. Consumer-directed proponents argue consumer involvement is paramount; however, due to the multidimensionality of the family and consumer construct, the level of this involvement is very difficult to measure empirically (Richards *et al.* 2008). As a result, there is inadequate research available that can be used to train professionals in integrating caregivers or family members into all aspects of mental health intervention (Worthington *et al.* 2001).

While there is a growing impetus for the use of evidence-based programs (EBPs) where statistically supported practices are emphasized (Petr & Walter 2005), the notion of family-driven treatment can often conflict with an evidence-based, prescribed approach to treatment. However, theoretical shifts are starting to appear in the literature, where 'the broadened notion of evidence-based practice recognizes the importance of the professional and the consumer in determining the relevance of the evidence to the situation at hand' (Petr & Walter 2005, p. 254). Many proponents of evidence-based practices (EBPs) argue that the clinician should integrate clinical practice expertise with external evidence gleaned from systematic research, critically evaluate the available methods and ensure that clients are informed participants, while also remembering the values and expectations of individual clients (Gambrell 1999). In fact, the Institute of Medicine now identifies EBP as 'the integration of best-researched evidence and clinical expertise with patient values', implying that EBPs need client or family values to play more of a substantive role in treatment (Institute of Medicine Committee on Quality of Health Care in America 2001, p. 2).

EBPS: THE LITERATURE

In order to compare FDST with other popular modalities while also suggesting its applicability for filling the gap between evidence-based family therapy models and consumer-driven treatment, it is neces-

sary to provide an overview of current evidence-based practices used to assist families. Current practices range from approaches and assessments that guide the development of treatment plans, to intensive therapy models used exclusively by clinicians. This review of popular clinical modalities is to inform the reader of the theoretical foundations of each approach, rather than being a critique of the research methodologies that have offered support for each model.

'Family systems of care' is a conceptual approach to working with families of children with SED that originated in the 1980s (Stroul & Friedman 1986). The wraparound process, a defined planning process individualized for each child that integrates community services and natural supports, emerged from this philosophy, and is considered a best practice by many in the field, with promising evidentiary results (VanDenBerg & Grealish 1996; Burchard *et al.* 2002; Stambaugh *et al.* 2007). Wraparound services are often used at the onset of services to facilitate treatment plans while highlighting the importance of involving child-centred, family-driven, strength-based and culturally competent care. The wraparound team develops an individualized service plan that builds on the unique strengths of each child and each family, and this customized plan is implemented in a way that is consistent with the family's culture and language. Wraparound services tailor treatment specific to an individual child rather than trying to fit children into one-size-fits-all programs. While the wraparound process is family centred, engaging families in shaping their child's services, wraparound itself is not a therapeutic model. The family needs to be involved in not only identifying appropriate treatment strategies for use with their children, but also by being integrated into the therapeutic experience, directing treatment session-to-session based on evolving familial and child needs.

The Family Inventory of Resources and Stressors (FIRST) assessment instrument asks parents to provide detailed information about resources and stressors in their lives in order to help guide treatment decisions (Corliss *et al.* 2008). This newly published assessment asks parents for their perceptions of the child's problems and invites their direct participation in the process to strengthen parent competency (Corliss *et al.* 2008). Similar to the wraparound process, the FIRST assessment is not a family therapy model; it is an assessment tool. The FIRST is a tool that encourages parent and family involvement, and should be recognized as another way to engage families in their child's treatment. However, although

parents and family members are asked to contribute to the assessment process, the FIRST does not engage the family in directing treatment from session to session.

A search of online academic and clinical resources yielded little information about emerging evidence-based family therapy modalities involving consumer-driven care. In fact, the only family therapy modalities subjected to evaluations using experimental or quasi-experimental designs were models utilized with children in the juvenile justice system, or who were receiving drug and alcohol treatment. Still, the application of these therapeutic modalities has paved the way for the development of more evidence-based, intensive work, with families by providing a framework for therapists working with families with children with SED, and therefore is worth some discussion.

Four therapeutic modalities have been developed that recognize the importance of families in improving children's behaviour and mental health. These four modalities are multi-systemic therapy (MST), functional family therapy (FFT), multidimensional family therapy (MDFT) and brief strategic family therapy (BSFT). Each of these modalities has been in development for the last 25 years, and has an empirical base to substantiate its status as an EBP or as a 'best practice' for social workers in the mental health field. Because all but one of these modalities focus on juvenile offenders or substance-abusing children, it is difficult to assure that these modalities are the 'best fit' for children with SED and families who may or may not have different needs than the populations studied. For instance, while research on juvenile offenders suggests that youth with mental health concerns are at a higher risk for involvement in the juvenile justice system, other evidence exists that indicates that most who are arrested do not have serious mental health concerns (Grisso 2008). Treating mental health concerns might reduce the risk of offending for this sample of the population; however, it does not address the causes of offending among the majority of the youth population. Although children with SED, juvenile offenders and substance-abusing children all need intensive services, these issues are not necessarily interrelated, hence pronouncements that a particular model works with one population may or may not imply that it will work with another.

MST focuses on altering the child's natural settings of home, school and locality in order to support positive conduct and behaviours (Henggeler *et al.* 1997). With supervision by MST developers and use of a

treatment manual, MST clinicians follow nine guiding principles to help families achieve therapeutic change and determine what interventions need to take place, including, but not limited to: understanding problems in the broader systemic context, using systems strengths for change, empowering caregivers to address family needs across varied systemic contexts, and interventions target behaviours within and across different systems (Henggeler *et al.* 1998). MST is usually provided for 3–5 months, and therapists carry caseloads of four to six families. Therapists are seen as experts, and are available round-the-clock to respond to families and crises (Henggeler *et al.* 1998).

MST has a large, broad, rigorous research base, and is often considered one of the premier EBPs in family therapy. Although this model is widely recognized and listed on almost every list of best practices for children and families, there are also studies of MST that have yielded inconclusive findings (Littell 2005, 2008). Funded frequently by juvenile justice authorities, MST is implemented most frequently with juvenile offenders and their families. Interestingly, one study focused on the use of MST in the prevention of psychiatric hospitalization, and focused primarily on using MST with children who qualify as SED (Schoenwald *et al.* 2000). However, in a follow-up study in 2003, the authors hypothesized that the needs of children with SED are intense, and a time-limited model such as MST may not meet the persistent issues that this population experiences (Henggeler *et al.* 2003). In a recent study, Painter (2009) evaluated a pilot project designed to use MST with youth who were seriously and emotionally disturbed who had no history of juvenile justice involvement. The author compared MST services against intensive case management and parent skills training. Preliminary results indicated that youth involved in MST improved to a statistically significant degree in lessening symptoms and improving functioning (Painter 2009). While these results are promising, further study comparing MST with other therapeutic modalities would be helpful in supporting the use of MST with the SED population.

FFT was founded at the University of Utah in the late 1960s (Alexander & Parsons 1973). It boasts a training manual, supervision and certification program, and extensive FFT implementation and adherence protocol, and focuses on multiple domains within and outside the family. FFT first develops healthier family functioning from within and then incorporates other social systems in the family's natural environment into the treatment process. With

its foundation in multi-systemic theory (not to be confused with MST), systems theory and behaviour change theory, three intervention and assessment phases are implemented across time: early, middle and late (Sexton & Alexander 2000). Each phase includes ongoing assessment, goals to engage and motivate the family, goals to change behaviours within the family, and generalization of changes made to the family's natural environment. FFT focuses on assessing total family functioning rather than on individualized diagnostic assessments with the primary client, and FFT emphasizes parental supervision and involvement as a mechanism for change within the family (Sexton & Alexander 2000). Sessions are highly structured and led by the therapist who focuses on teaching and practicing new skills with family members in each session. Assignments are given to family members between sessions, and are designed for the family to work towards additional change in behaviours. Treatment duration was difficult to discern from the literature, therefore assumptions can be made that FFT may have more flexibility in this area than other comparable models.

Similar to MST, research in regards to FFT also primarily involves juvenile offenders and their families with most recent study focusing on substance abuse (Waldron *et al.* 2001). As mentioned previously, it is likely that a small percentage of juvenile offenders also experience symptoms synonymous with the SED population. Even so, research to date has not focused primarily on the effectiveness of FFT with children as SED as their primary area of concern. Moreover, although supporters of FFT report that the model has generalizability to other populations, Sexton and Alexander (2000) stress that strict adherence to the model is crucial, or the clinician can do more harm than good.

MDFT aspires to advance family functioning and decrease or eliminate child substance abuse (Hogue *et al.* 2002). MDFT developers assert that MDFT promotes the development of healthy peer relations and positive identity creation while finding a balance for children between their independence and the emotional bonds shared with their parents (Liddle *et al.* 2001). Parent goals include enhanced relationships/communication with children, improving parent commitment to the child and their problems, and increasing knowledge about parenting practices (Liddle *et al.* 2001). Interventions can range from mildly intensive, lasting 3 months, to very intensive, over a 6-month period, depending on the needs of the client. MDFT services can be delivered in-home, in

the community or in an outpatient setting. The development of a therapeutic alliance or 'engagement' is essential with MDFT (Hogue *et al.* 2005). There are five specific assessment and intervention elements that constitute MDFT, including interventions with the adolescents, parents and other family members, changing the parent-adolescent interaction, and intervening with systems external to the family (Liddle 2003). The research for MDFT focuses primarily on its application with urban, minority youth who are involved in substance abuse; therefore, generalizability to the SED population is limited.

In BSFT, the family is the 'bedrock of child development', and clinician sensitivity and responsiveness to contextual factors is key (e.g. child in context of family and the family in context of larger society) (Szapocnik & Williams 2000). BSFT proponents believe that 'engaged' families using BSFT will improve their functioning, thus 'engagement' will also positively influence the rate of retention of families in services (Szapocnik & Williams 2000). BSFT offers formalized training and supervision to assist with the structural and strategic interventions: BSFT focuses on the structure of the family, and recognizes the importance of family in youth improvement. Further, BSFT is time limited, and intervention strategies employed by therapists are premeditated and deliberate. To date, this model has been primarily studied with Hispanic children and families. While many suspect that the prevalence of SED is under-reported among minorities, recent statistics suggest that only 5% of the SED population is Hispanic (Substance Abuse and Mental Health Services Administration 2005). Therefore, BSFT's applicability to children with cultural and ethnic backgrounds different from Latinos has yet to be determined. Unlike other family therapy modalities, however, BSFT focuses on children with mental health, emotional and behavioural concerns vs. juvenile justice or substance abuse issues.

The models reviewed above rely on prescribed, therapist-focused interventions to mold the change process, and most often focus on the functioning of the individual as the identified client. For example, MST asserts 'clinicians determine the factors in the caregivers' lives that are interfering with their capacity to provide necessary nurturance, monitoring, and discipline for the child' (Henggler *et al.* 2002, p. 8), thereby suggesting that clinicians are the experts who impart knowledge to create family change. BSFT uses deliberate, premeditated interventions instructed by the clinician (Szapocnik & Williams 2000, p. 119). In

MDFT, progressive modules are determined by the clinician over a fixed 16-week period (Liddle 2003). And FFT treats the therapist as an expert who teaches family members new skills and leads children and families through change via highly structured settings (Sexton & Alexander 2000). Unfortunately, there is a lack of evidence-based practices that encourage families of children with SED to drive the therapeutic treatment.

A consumer or family-driven model must assert that change lies with the consumers and families themselves, and draw on family members to shape interventions and change based on their personal values and needs at the time. Further, a consumer-driven philosophy suggests that the clinician's ability to guide family members in directing their own change is critical. While clinicians are experts in their field with high levels of training and experience, consumer-driven proponents reiterate that families are also experts, knowing what will and will not work in their own family environment and needing the opportunity to direct their own treatment as changes occur session to session.

An EBP is needed that is flexible, is not prescribed or premeditated, and which allows the family to take the lead in guiding treatment, yet also has the empirical tenacity to show effectiveness. 'Science' or empirical evidence of effectiveness in therapeutic interventions can be effectively blended with consumer-driven care so that the flexibility needed in the family's daily environment is both supported and contributive to therapeutic success. While the highlighted models discussed above are undeniably valuable and delineate the importance of collaboration and flexibility while maintaining fidelity in their approaches, the consumer-driven component still appears to be missing. New methods designed to enhance the engagement of children and families in directing their treatment, throughout the therapeutic process, hold promise to close the treatment circle – to put the family first in all aspects of the therapeutic encounter.

FDST: ENCOURAGING FAMILIES TO DIRECT TREATMENT

FDST is an emerging approach that addresses the importance of consumer-driven care. In contrast to the view that therapists are experts who orchestrate treatment, this model views therapists as guides who help families navigate the treatment process (McLendon *et al.* 2005). This concept is somewhat akin to

Marlow & Sauber's (1990) view that therapists are 'invited guests', there at the discretion of the family to help address their desired wants and needs (p. 83). Different than an expert, a guide provides individuals with the opportunity to make a choice about the direction they want to pursue. Like the guide hired by mountain climbers to lead the way on dangerous terrain, the therapist is hired by the consumer to lend his or her expertise to the journey the family has chosen to take. The family chooses the destination, however, and relies on the expertise of the therapist to help guide them to safe passage.

Based on group theory, the strengths perspective, and structural therapy, FDST uses an assessment tool to prioritize treatment concerns while also engaging the family in a therapeutic process. This assessment tool gathers a great deal of information from numerous people in a short amount of time, is visually appealing and easy to understand, and blends different approaches into a model that is strengths based, structured, family focused, and can be easily used with groups of people, including families. As a basic tenet, FDST holds that adults are the fulcrum of power and source of change in the family (McLendon *et al.* 2005). Core issues, originating from the developer's 40 years of practice experience as concepts central to the foundation of family functioning, are defined as follows: commitment – the willingness to see things through despite differences and conflicts; empowerment—feeling one's opinions are valued, heard and respected; control of self—the ability to change behaviours when needed; credibility—doing as one says s/he will do; and consistency—behaviours and communications are predictable (McLendon *et al.* 2005).

A diagram of a family circle is presented at the beginning of the assessment tool that helps parents and families define boundaries and structure in their family as the family sees fit. The family circle is a visual representation of the external and internal boundaries present within a family. (See McLendon *et al.* 2005 for a visual depiction of the family circle.) While the FDST assessment tool helps apply structure to both the family and to the helping process, the family ultimately determines who is in their family, how they want their family to function and what they want their family to look like.

Adult family members complete an assessment tool that asks them to numerically rate the five core issues and roles (different jobs in the family including adult partner roles, adult individual roles, parent roles, and child roles), and 16 external stressors, including

finances, living conditions, grandparents and hobbies. A scoring scale of 1–4 (including not applicable) is utilized, where 1 indicates an area is positive, 2 indicates an area is mostly positive with some negative, 3 indicates an area is mostly negative with some positive, and 4 indicates that the area is negative (McLendon *et al.* 2005). Either couples or single adults involved in parenting rate the tool independently without input from others. At the conclusion of completing the assessment tool, service providers combine these scores to use in identifying the family's strengths and the family's areas of concern using the scores from the assessment tool. Finally, a framework of interaction offers service providers and families additional techniques for therapeutic change, such as creating rules to fight by, using 'I' and 'Me' messages, and agreeing to disagree to help resolve conflict (McLendon *et al.* 2005). The techniques and strategies that comprise the Framework of Interaction are not unique to this model. The concept of 'I' and 'Me' messages dates back to Virginia Satir in the 1970s, while the strengths model was initially highlighted by Saleebey in the 1990s (Satir 1972; Saleebey 1997). It is important to note that children are included in the process after adults have completed the tool and identified where they want to begin their work. For information about FDST in greater detail, refer to McLendon *et al.* (2005).

The assessment phase highlights different areas of concern to the family, and then the structure of the model directs them to decide where to start. Significantly, the therapist does not tell the family where to start; the assessment tool is designed so the family is able to decide where to start its work. The assessment tool both initiates treatment and then guides treatment session to session. Similar to other modalities, FDST identifies strengths and teaches concrete skills. However, FDST supports communication and skill development by reinforcing a 'common language' with therapists, service providers and family members (McLendon *et al.* 2005). By using a similar vocabulary, communication is heightened, the risk for misunderstanding is diminished, and skills are reinforced through language, as well as through change in behaviour.

This model has both a structural and functional application of core issues, which serves as the foundation of the therapeutic intervention. In FDST, core issues as defined previously are the fabric of family functioning. These core issues are first applied by family members to the overall family structure, and then applied functionally to individual areas of

concern. As an example of the structural application, a spouse rates his/her level of commitment to addressing general family issues. The remaining four core issues are applied similarly thereafter, with the family and clinician exploring how each core issue influences general family functioning.

Next, core issues are applied functionally to specific areas of concern. For example, an adult family member rates his/her level of commitment to addressing problematic finances, arriving home from work in a timely manner, or decreasing spousal conflict. The other core issues are then applied, with each partner rating the degree to which his/her opinion is valued and respected in reference to the area of concern (empowerment); his/her ability to change behaviours to address the problem (control of self); the extent to which the individual can implement change behaviours (credibility); and level of ongoing predictability in reference to addressing the area of concern (consistency).

In consumer or family-driven care, it is up to the family to determine 'what the problem is', and FDST is designed to help them do that. Similar to FIRST, it has a detailed assessment process in which stressors and resources are identified. However, FDST is very different from the assessment approaches and collaborative tools detailed above. Not only does the FDST assessment tool gather initial assessment information, the tool is also simultaneously a 'living' document, changing with the family yet providing structure to help the family prioritize and facilitate treatment. The tool is in itself a therapeutic vehicle constantly engaging family members in driving therapeutic change. At the same time, the tool also tracks the family's perception of changes over time with a numerical score. For instance, the first time a family scores the tool, *credibility* might be a 3. With the appropriate interventions, the next administration might indicate that credibility improved to a 2, indicating a 25% change during the therapeutic process and providing a measure of the progress made in accord with the treatment goals and expected outcomes.

As mentioned previously, FDST has its roots in group theory. In group work, the group itself is the vehicle for change; responsibility for change lies with family, not the service provider. Similarly, the family is the vehicle for change in FDST. The group process and the work put forth by the members of the group are the major agents of help (Anderson 1997). Clinicians can guide families in the group process; supporting the changes they want to make and 'letting go' of the changes the family is not committed to pursuing.

It is the clinician's job to help consumers process and work through what they want to work on and also provide the structure for them to do so.

FDST IN ACTION: FAMILY-DRIVEN CARE IN THE SMITH FAMILY

An example of how FDST looks in action will help illustrate the application of FDST principles and techniques. For instance, Molly Smith, a mother in her mid-40s, brings her daughter, Shanna, a Caucasian 14-year-old, to Riverdale Community Mental Health Centre for assistance with depression and generalized anxiety disorder. Shanna and her family moved to the area 6 months ago. Within the last 3 months, Shanna has been skipping school, refuses to take her anti-depressant medication, is on diversion for shoplifting, often talks about death and dying, and sleeps all of the time. Shanna received services in her last place of residence; however, the family did not resume services after their move to Riverdale. As a condition of diversion, Molly and her husband Bill, also in his mid-40s, agree to resume mental health services for Shanna.

Sara, a new therapist at Riverdale, meets Molly and Shanna during the intake process. Sara explains that she has just been trained in a promising new model called FDST, and since Bill and Molly are the fulcrum of power and source of change in their family, Sara requests another meeting where both Molly and Bill can be present to complete a FDST assessment tool. Molly is perplexed at this new method and indicates at the last mental health centre, she just dropped her child off for individual therapy once per week. Sara explains that current evidence shows that better outcomes emerge when you engage the family in the treatment process, and that family-driven treatment is a consumer-driven approach consistent with the values of the mental health centre. Molly reports feeling desperate to help her child and agrees to bring her husband the following week to complete the tool.

Molly and Bill complete the assessment tool. Molly and Bill determine who is in their family and who is not and address what boundaries look like in their family. After scoring the assessment tool, they are able to highlight strengths in their family as well as prioritize areas they wish to work on. They are consistent in how they see their family, and they are committed to helping Shanna improve certain behaviours. However, they report problems with finances, employment, parenting, their marriage, and identify how the school

and judicial system have negatively impacted their family. They report being most committed to working on their parenting, marriage and helping Shanna, and less committed to working on finances. They hope if they can help Shanna, the school and judicial problems will eventually subside. Shanna is brought in at the end of the session, and they review boundaries in their family, what they decided to work on, and how it was going to impact Shanna. Sara reviewed the common language with all family members, and the family really liked the core issues and some techniques from the framework of interaction, such as creating rules for family arguments and the concept of moving in the right direction. However, they did not like the suggestion from the framework of interaction to agree to disagree and it was put aside, not to be used again unless the family chose to do so.

During the month after administering the assessment tool, Sara met with both the parents and with Shanna to work on identified areas of concern. Sara assisted family members and Shanna with applying core issues structurally and functionally to the family, as well as individual issues. For instance, Shanna reported being committed to her family and decided she needed to change behaviours, such as going to school. She realized that her mom missed work often because of disciplinary meetings at school, and hoped that going to school might show her parents that she did care about her family and she was willing to try to help the situation. In regards to a specific area of concern, decreasing Shanna's shoplifting, core issues were applied functionally and Sara asked Shanna, 'How committed are you to decreasing shoplifting?' (commitment), 'What behaviours need to change to decrease this behaviour?' (control of self), 'Do people listen to what you have to say when you talk about shoplifting and why you do it?' (empowerment), if you say you will stop stealing, can you do it (credibility), if credibility is a concern, what needs to change to address this (control of self, again), and do people predict if you will shoplift when you are out or is there something else going on to cause this behaviour (consistency)?

Shanna revealed that she did not want to go on probation, so she was committed to change. She believed that she was shoplifting with specific friends and thought that if she stopped hanging out with them after school, she might not shoplift anymore. She did not think her parents listened to her when she tried to discuss this issue with them, yet agreed her credibility was not very good, and she continued to shoplift even though she said she would not. Shanna shared

that her parents and others could predict her behaviour, and they knew what to expect from her. As a result of this intervention, Shanna also targeted other areas to work on, including empowerment with her parents, credibility, and learning to control her actions and change behaviours that need to change.

On a couple of occasions, Bill and Molly wished to shift focus on the interventions because they saw other needs that were more pressing, or they believed the problems had resolved themselves for now. Although Shanna continued to struggle with depression, the family chose to take control of what they believed was reasonable. By working together as parents, they decided to more heavily enforce strict oversight of Shanna before and after school. Molly asked her mother to stay with Shanna on Monday evenings while she and Bill went out to dinner in an effort to strengthen their marriage. Molly and Bill took turns bringing Shanna to individual therapy and made sure that she did not miss an appointment. Shanna's school work did not improve; however, her truant behaviours decreased, and she was no longer shoplifting. Shanna, although still not taking medications as suggested by the doctor, was spending more time with her parents and began talking with them more about her symptoms. While this communication did not inherently make her symptoms go away, it helped the family restore their ability to take control of the situation and manage Shanna's behaviour until therapy and other interventions helped her cope more effectively with her depression. The family directed what they wanted to work on, suggested what they thought they could or could not do, and actively directed or contributed to the problem-solving process based on their values, expectations and level of commitment to treatment. While Sara could have focused on finances, homework completion, parenting skills and more, she instead guided Bill and Molly in framing what they wanted their family to look like and assisted them with driving the change needed to put balance back in their ability to cope with Shanna's difficulties.

CONCLUSION AND IMPLICATIONS FOR FURTHER RESEARCH

As seen in operation in the Smith family, FDST is goal-oriented, time limited, and usable in any setting. This approach supports the tenets of consumer-driven care while focusing on family direction and supporting the values embraced by social workers, specifically those of client empowerment and self-determination. In essence, from assessment through termination, the

family directs and becomes an integral part of the treatment. When helped to identify their options and their desired outcomes, families are able to express what is best for them and what they believe will and will not work. When families drive treatment, the assumption is that change is sustained when the services end because the family system changed to support those changes. In fact, it can be said that because the services are family driven, they do not end; they instead become a natural part of the family's way of operating.

As a result of both clinical wisdom and the changing landscape regarding parental involvement in the 1960s and 1970s, the creator of FDST recognized that involving the family in the treatment of children just 'made sense'. Current research across multiple disciplines including teacher education, early childhood, health care, and social sciences mimics these assertions, suggesting that family and parental involvement are keys to producing positive outcomes (Gaertner 2010; Heinberg *et al.* 2010; Jeynes 2010; Kay 2010). These views about the importance of involving families in the care of children illustrate the need for a family therapy approach that integrates parents and families in driving treatment while also addressing the directive that service providers utilize practices with an evidence base. While there are many family therapy models with a rigorous scientific base, these models have not been well studied, if at all, with children with SED.

Although further study is needed to evaluate FDST as a legitimate evidence-based practice, current research with FDST demonstrates that consumer- or family-driven interventions with children with SED and their families can be achieved with promising empirical support. Two recent FDST outcome studies involving quasi-experimental designs with comparison and treatment groups suggest promise as an effective family-driven practice (McLendon *et al.* 2008, 2009). For instance, in a study that took place in a therapeutic wilderness camp, treatment families improved to a statistically significant degree on 8 of 12 FDST measures (McLendon *et al.* 2009). Additional research is underway with a large community mental health centre in the Midwest in an attempt to further assess the effectiveness of interventions, the impact of improving core issues on family functioning and the assessment tool. Future studies aim to evaluate the claim that improving familial role scores and core issues will likely improve child functioning or help the family's ability to cope with mental health concerns in a positive, healthy manner and achieve lasting change.

FDST is flexible and blends clinical wisdom with consumer-driven care so that the family's daily environment is both supported and contributive to therapeutic success.

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