BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR
FAMILY THERAPY

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TREATMENT PLAN FOR FAMILY THERAPY 14

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Executive Summary

Statement of intent:
This series of treatment guidelines was created to assist SCF behavioral health clinicians and administrators in program development, treatment planning, and service delivery. They were created by examining the most common and most severe problems and diagnoses seen in our clinics and by looking at the treatment modalities most often used to address these problems. The first step was a review of the published literature surrounding each diagnostic group and some of the modalities used to treat them. The second step was assembling a team of clinical and administrative staff to read the reviews and some of the primary literature, and to consider how it applies to our treatment setting. These groups met multiple times to evaluate the literature and our programs, and to define how we believe these problems can or should be addressed within our setting considering our program goals and resources, and the resources available in the broader community. The third step was drafting the guidelines. The guidelines were written with the explicit intention of guiding treatment that is:

- Informed by the literature and evidence base
- Acceptable to patients, clinicians, and administrators
- Effective
- Efficient
- Consistent with the goals and values of our organization and the native community

What is Family Therapy?
Family therapy can be broadly defined as any intervention in which the family unit is the focus of treatment. In family therapy, the family unit must be viewed as a whole, rather than a composite of the individual members. It postulates that the behavior of one family member can best be understood by examining the context in which it occurs. A family unit can have multiple compositions: single or two-parent families, birth and adoptive families, family's with minor children in legal care, foster families, adoptive families, and extended families. Interventions must be implemented at the family level, and take into account the complex relationships in the family. A premise of family therapy is that by enhancing family relationships, undesirable behaviors in family members will decrease.

Expected General Outcomes:
Family therapy or treatment seeks to increase family cohesiveness, improve parental authority, and decrease disruptive behavior in a child or children. Family therapy may be used when the focus of treatment is to modify the behavior of a family member, such as a child, by effecting a structural change in family system. According to the family therapy approach, the behavioral symptoms of a child are directly related to the interelational problems in the family. As a result, changing the family system can positively impact behaviors in family members.

Common Indications
From our clinical experience and from review of the literature, we have compiled lists of common problems, traits, and diagnoses of children, adults, and families that can benefit from treatment with family therapy. Please use these lists, contained later in the guideline, to decide if a particular patient or family might benefit from this modality and to answer questions about how our clinic addresses these problems and issues.

Treatment Barriers:
From our own experiences providing this treatment and from a review of the literature, we can define some common impediments. The following things typically limit our ability to deliver treatment, or the effectiveness of the treatment:

- Clinic time and availability of trained clinical staff (the models with the greatest evidence of effectiveness often require specialized training and materials)
- Resistance to treatment by one or more family members
- Limited availability of convenient daytime and weekend treatment times for clients
- Transportation for clients
- Childcare for clients if some children in the family cannot participate
- Financial concerns for clients
- Cultural barriers
- Untreated psychiatric issues
- Lack of education and/or acceptance about a family member's psychiatric issues. (For example, if a family member has a psychiatric condition, or another illness interfering with their role in the family, education about the disorder must be concurrent with or part of the family intervention.)

Summary of treatment models:
We are referring to all family counseling or therapy as a single modality, but within that modality, there are many treatment theories and models. This guideline contains a table of therapies currently available in our clinic, a summary of four empirically validated family therapies prepared by our research consultant, and a synopsis of these same four therapies prepared by our own clinicians and highlighting current barriers to their implementation in our system.

Further program development in this area should include examination of these proven programs, the current barriers to their implementation, and the other family oriented programs within our organization. The scope of resources and potential integration is broad including the young families program, Family Wellness Warriors Initiative, The Young Men's Initiative, and the education and parenting work of the Pediatrics department, Health Education, Nutaksuvik, and our own behavioral health department.

Common Indications

Families may have significant distress and seek treatment on their own, or an outside system, such as OCS or the courts, may propel a family into therapy.

Family therapy can be helpful for families with children who are diagnosed with a variety of disorders including ADHD, impulse control disorder, SASD, ODD, OCD, conduct disorder, adjustment disorders (related to grief, loss, separation, blended family issues), bipolar disorder, eating disorders, sexual abuse, and high-risk behaviors. This list is not exhaustive. Family therapy is not limited to only those disorders mentioned above. Family Therapy may also be selected when the primary difficulty stems from parental control difficulties, such as lack of appropriate family structure, hierarchy, communication and limit setting difficulties.

Common behaviors or problems prompting treatment include:

- Family discord
- Parenting difficulties and/or loss of parental control
- Academic and behavioral problems
- Delinquency issues/high risk youth behaviors (running away, self harm, sexual activity)
- Youth substance abuse
- Emotional abuse
- Sexual abuse
- OCS involvement
- Juvenile criminal system involvement
- Foster family involvement

The following indicators are often seen in children who may benefit from family therapy:

- cultural identity confusion
- rejection of culture of origin
- behavioral problems in school or at home
- early antisocial behavior
- association with antisocial peers
- feelings of inadequacy and immaturity
- poor self discipline
- poor frustration tolerance
- poor self concept
- unconventional beliefs or attitudes

The following indicators may be seen in the parents:

- poor parent-child communication skills
- parent-child conflict
- parent-child cultural conflict
- negative, harsh or critical affect in family interactions
- marital problems
- family isolation
- ineffective parental behavior control
- parents uninvolved with child, child's school and/or child's peers
- parent or older sibling involved with drugs or other inappropriate activity

Demographics of a family

The definition of family is a fluid one, and to some degree, self-selected. Families include heterosexual or homosexual couples with children, single or two-parent family units, biological and adopted families, families with members in legal care, foster families, and extended families. One common theme, however, is that interventions must be implemented at the family level and must take into consideration the complex relationships within the family. A tenant of family therapy is that by improving family relationships, the behaviors and relationships of individual family members will also improve. Deciding which individuals in a complex family unit or household need to be involved in the treatment is one of the challenges of family therapy.

Diagnostic Categories

Most of the well researched models come from working with families that have a child with disruptive or aggressive behavioral problems. **Substance abuse**, **conduct disorders**, oppositional defiant disorder, and **depressive disorders** across the age spectrum of 11-18 years old are common disorders evaluated and diagnosed in these families.

Among the most common diagnoses of children seen in our clinic are **Adjustment disorders.** An adjustment disorder is diagnosed when signs and symptoms of distress and impaired functioning are caused by a specific stressor or trigger. Adjustment disorders in children are often best treated at the family level. Circumstances and events that may make a child vulnerable to or trigger an adjustment disorder include:

- Substance abusing parent or sibling
- Disengaged parent(s)
- Abusive parent(s)
- Neglectful parent(s)
- Inconsistent parenting
- Blended family issues
- Conflict
- Separation/Divorce of parents
- Peer groups issues -bullying, peer pressure, teasing, discrimination
- Domestic violence in the home
- Birth of a sibling
- Accidents or serious illnesses
- Grief/Loss
- Academic failure or difficulties/challenges in school, learning disabilities
- Poor self esteem
- FAE/FAS
- Unresponsive academic or social system
- Psychopathology in the parent, sibling or other family member
- Sexual abuse, emotional abuse and physical abuse

In situations where anger management is an issue, for either the parents or the child(ren), the clinician may refer an individual for initial or concurrent anger management treatment.

Group Family Therapy
Working with multiple families in one group is NOT the treatment of choice. Family therapy where the group consists of members of a single family unit and appropriate clinical staff is the preferred clinical approach.

Table of Models

Treatment Model Name	Brief Strategic/Solution Focused/Narrative Therapy
Brief Description	Identifies the patterns of relationships and interactions within the family system. The goal is to restructure that family by working in the present, reframing individual dysfunction as a systems problem, improving family boundaries and creating healthy alliances. Targets children 8-17 years old that are currently displaying, or at risk for, behavioral problems and substance abuse. The Solution Focused approach poses the miracle question, and helps the family identify and build on its strengths. Clinicians help to externalize the problem, and assist family members to consider what they can do in service of the solution.
Resources Needed	Masters level Clinicians must be trained in the specific family therapy models, and understand the theoretical foundations and skill sets of the model.
Target Group	Children 8-17 At risk of behavioral problems or currently displaying behavioral problems. Treatment allows for early intervention/prevention as well as crisis intervention.
Structure	Individual family, closed. 12-16 sessions.
Concurrent Treatment(s)	N/A There may be complementary or conjoint treatment. A useful adjunct for parents may be parenting classes and education, stress reduction, and anger management. For children, conjoint treatment may be group therapy to for specific needs (i.e. social skills group, grief/loss group).
References	Brief Strategic Family Therapy. SAMSHA Model Program. http://modelprograms.samhsa.gov Mandanes, C. 1981 Strategic Family Therapy. San Francisco, CA: Jossey-Bass Minuchin, S., and Fishman, H.C. 1981. Family Therapy Techniques. Cambridge, MA: Harvard University Press

The above Table is a reflection of the Family therapy currently offered in the BHF clinic. It contains many of the elements common to the empirically validated forms of family therapy, but has not been systematically evaluated for adherence to a particular model. Enhancing and expanding the family interventions offered in our clinics is consistent with the goals of our organization and an appropriate focus of program development.

Other Family Therapy Treatment Models

1. Brief Strategic Family Therapy (Robbins & Szapocznik; 2000) – Using this framework, the clinician joins with the family, and identifies the patterns of relationships and interactions in the family system. The clinician then works to restructure the family, by working in the present, reframing, and establishing boundaries and healthy alliances. It targets children ages 8-17 that are displaying, or at risk for, behavioral problems and substance abuse. This program, endorsed by the Office of Juvenile Justice, is a SAMHSA model program.

In general, treatment spans 12 – 15 sessions over 3 months, and is conducted in the clinic and in the community.

2. Multi-dimensional Therapy (Schmidt, Liddle et al 1996)– It is a multi-component, systemic treatment approach that occurs in the clinic and community. It combines strategic and structural family theories. There are four chief four target areas for intervention; 1) quality of functioning within interpersonal relationships; 2) quality of parental interpersonal functioning; 3) parent-adolescent interactions and dynamics; and 4) identification of extra familial influences on the family and the family response. It takes into consideration the child's school environment, the social life of the parents, and significant social influences on the family, such as church. This approach is long term, intensive and a high resource treatment approach. Additionally, there are specific modules and a manual clinicians use in this structured treatment

Noted treatment barriers are – long term commitment to treatment and resource intensive. Special training components need to be purchased by the clinic, and staff must be trained in the approach.

3. Functional family therapy (Sexton and Alexander, 2003), in contrast, is a short term approach. It targets families with children ages 11 – 18 years old, and is done over 12 to 16 sessions. According to this approach, pathology is embedded in the family. As a result, behavioral symptoms are interpreted as relational problems. Specific problems, then, are considered as a manifestation of the family's relational problems. This approach focuses on child-family relationship patterns, connections among family members and the relational hierarchy. Interventions are taken to improve the functioning of the family through addressing issues of family structure, hierarchy, alliances and levels of relational engagement and/or disengagement.

Treatment Barriers – This approach requires significant training in the Functional Family Therapy approach for clinicians, and requires adherence to the principles and interventions of the approach.

4. Multi-systemic Therapy (Stanley et all, 2000; Sheidow, et al 2002; Henggeler et al, 1986) – This manualized program requires a team that provides 24/7 services, and treatment generally lasts 4-6 months. Clinicians work with 4-6 families at a time. The goal is to train and support the family in how to deal with, and resolve, their unique problems by developing family capacity and skills. This model is well studied and researched, and the literature suggests it is cost effective and therapeutically effective.

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder
Structural Family Therapy (SFT)	Structural Family Therapy is model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which

	the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.
Seeking marital aide	Notion of impaired relationship)

Appendix B: Literature Summary

Evidence Based Clinical Guideline
Southcentral Foundation Research Project
Summary Sheet
Family Therapy

Diagnosis: This is not a diagnostic category. Nevertheless, the importance of family in the diagnosis of many disorders is without question. Functional assessments, in particular, rely on how a client interacts within the family structure. Likewise, Axis IV on the DSM system provide family-based evaluations and information as well does the ASAM criteria. Within the Family and Marriage therapy domain, family structure, process and functioning can be "diagnosed" within broad categories. Therefore, the understanding of evidence based family interventions is very important to the outcome and efficacy of any comprehensive system of care(Kumpfer, 2003).

General Information: Family is a concept that carries many interpretations and controversies. What constitutes a family? What structure must a family take? What are functional family processes? How does the individual affect or get affected by family? How does one enter a relationship with a group (family)? Who in the family must be involved in any treatment? How does the clinician maintain family participation and adherence? Finally, how does family provide such strong healing action? These questions and others, serve as a starting point in the development of coherent and comprehensive treatment in the behavioral health world. How each clinician, agency and system defines and answers the above question will determine the effectiveness and usefulness of family therapy.

Tomes and ten thousand papers and briefs have been written on family therapy. It is not the intent of this brief discussion to outline the multitude of theories, programs and interventions based on family. More over, when plugged into any search engine at APA, Evidence Based Mental Health, NIH, NIMH, Medline or Medscape, family or family therapy generate thousands of hits. For evidence or research supported family interventions, the number of unique hits (programs or brands) diminishes significantly. For this brief review (believing that family need therapy when some body is acting out or in), the literature outlines four major, well research family therapy programs. This review then will focus on those four, provide resources information and general outline. Mostly though, I want to target the common factors of these and other systems of family interventions. Again, this will not be comprehensive but will outline the factors that arise that best inform practice. Any family therapy text can outline the major schools and theories of family therapy. I refer you to any of them.

Therapeutic Models: Most of the well researched models come from working with families that have a child with disruptive or aggressive behavioral problems. Substance abuse, conduct disorders, oppositional defiant, aggressive or agitate depressive disorders across the age spectrum 1-18 years old are common disorders evaluated and diagnosed in these families. This makes sense in that seeking help necessitates a precipitating force.

<u>The four model of family therapy (different than parenting) for this crucial population are:</u>

Brief Strategic Family Therapy (Robbins & Szapocznik; 2000): Originally targeting minority children from Hispanic families, this program is now a SAMHSA model program and highly lauded by the Office of Juvenile Justice. Based on three cardinal components for interventions in high stress and conflicted families the BSFT models the elements of Joining, Diagnosis (identifying patterns of relationship and interaction) and Restructuring (working in the present, reframing, and establishing boundaries and healthy alliances). This particular model understands the power of extended families and strong family structure. It targets children 8-17 displaying or at-risk for behavioral problems including substance abuse. It falls under the brief moniker because it is 12-15 sessions over three months. It works in a systematic and coherent manner with the parents, sibling and identified client. Conducted both at the office and in the community, BSFT has demonstrated positive outcomes in cost effective ways. There is training, manual and literature available for the implementation of the principles and negotiation of the choice points for the therapist.

Multidimensional Family Therapy (Schmidt, Liddle et al 1996): is another multi-component systemic treatment intervention with good evidence to support it. It has been successful in dealing with substance abusing youth 12-18 years old from multiple cultural backgrounds. It is combination of strategic and structural family theories and integrates developmental and affiliative thinking. Manualized in 1992 with specific modules developed by Liddle (1992) the MDFT focuses on four target areas for intervention: functioning within interpersonal relationships; parental interpersonal functioning; parent-adolescent interaction and dynamics; and extra familial influences on the family and family response. Individual pathology and symptoms are interpreted within the context of the family and environment. This is a family-ecological approach that demands in office, in community and targeted problems solving and training within the family. MDFT require coordination of services, case management, psychoeducation and therapy across many contexts, interactions and timeframes. The literature on this model demonstrated better outcomes than group therapy and psychoeducation for adolescent substance abuse and conduct disorders. This model, MDFT is a blueprint Best Practice for adolescent substance related disorders and disruptive disorders as noted in 2002 by the Dept. of Health and Human Services, USA.

Functional Family Therapy (Sexton and Alexander, 2003): This short term model is 12-16 session over 3-6 months targeting 11-18 year old youth. Younger children have been seen. This is an open, dynamic and responsive model that rests on strong principles that guide interventions. First, FFT view pathology as imbedded within the family and interpret symptoms as relational problems. Second, specific problems are viewed as manifestations or communications of the family behavioral pattern. Third, FFT posits that the risk/protective actions of the family are maintained by the way the family relates and functions. Focused on the relationship aspects of the family specifically the child-family pattern relationship, connection and relational hierarchies are important matters to attend to. FFT posits that change happens through four component inherent in the interventions: alliance motivations; meaning change preceding behavioral change; change goals reflect the culture and abilities of the family; and all interventions match the family in multiple facets such as cultural, education, needs or any other unique characteristic. This program requires fidelity to the principles and interpretations. There are systematic training programs, manual (maps) and clinical supervision available. The outcomes of the over 90 programs throughout the US has shown tremendous utility and effectiveness within cost management parameters.

Multisystemic Therapy (Stanley et al, 2000; Sheidow, et al 2002; Henggeler et al, 1986): This is one of the most studies and researched models of family intervention. A model based on Fit, Strengths, Responsibility, Here and Now, Ecological Sequencing of targeted behaviors, Developmental Appropriateness, Continuous Effort and Accountability, and Generalizability. MSF acts across the life space and time of the child and family. This Manualized program outlines the basics of MSF in evidence supported positive outcomes with children dealing with delinquency, substance abuse, chronic and severe emotional disturbances and their families. The Therapist has a case load of 4-6 families and works within a team that provides 24/7 services that prevent crises, out-of –home placements and goal failure. MST generally lasts 4-6 months. The overarching goal of MST is to training and supports the family in how to deal with and resolve effectively serious clinical problems. The focus is on developing family capacity and skills to deal in the unique ecology of that family. This model uses strong clinical skill and positive interventions (Huey, 2000). This is a very cost effective, efficient and humane program that has served communities and agencies well for years.

General Factors Across all the EB Family Programs: (See Ozechowshi et al, 2002)

Engagement: See Santisteban et al: 1996; Snell-Johns, 2004

Reframing: Infusing the current negative or conflicted situation with a new, novel or apparent alternative explanation that is plausible, sensitive and positive.

Enactment: The direct and purposeful intervention from the therapist to execute change or assess changes that have happened.

Mulitsystemic Interventions: Incorporating all relational connections: Juvenile Justice, Extended family, School, Faith-based Organizations, Peers, Voc Rehab, Social Services, and others as well as the client and immediate family. This ecological view of pathology and healing has proven far superior to any individual, group or educational programming or sequential combinations.

Lastly, Family psychoeducation has been shown as an evidence based practice for severe mental illnesses and dual diagnosis. (see Summaries on Dual Diagnosis and Schizophrenia). Multifamily education has been published as the practice of choice and evidence based practice for severe mental illness (Implementation Kit included)

Cultural Considerations: Many of the above mentioned models were first developed for minority groups. Although not Native Alaskan in focus, many of the principles, foci and interventions seem suitable and sensitive to the realities in the bush and remote Alaska as well as urban Native groups. Because some of the models include video and self directed components, this can help bridge the lack of personnel, resources and mis-trust issues that are present in many such interventions and agencies. Lastly, the privileging of cultural meaning, structure and outcome while conscientiously and planfully advancing evidence based interventions into any culture or family system is one of the cardinal components of family therapy.

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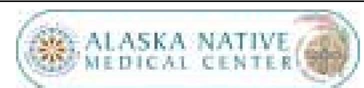

Appendix D: Sample Treatment Plans

Treatment Plan for Family Therapy

Problem #1:
Parent-child conflicts, sibling conflicts, blended family issues, teenager issues related to dependency/autonomy, social conflicts, peer conflicts.

As evidenced by:
Frequent parent-child conflict, sibling conflict, disobedience or breaking the family rules by the child(ren), poor communication, lack of trust and/or mutual respect, emotional disengagement, poor boundaries and/or limit setting by parents, inconsistent parenting. (The symptoms will be unique to the family being treated. Use there own descriptions whenever possible.)

Goals:
To decrease overall frequency and intensity of family conflict, enhance mutual respect and consideration of other family members, increase overall positivity within the family, develop and maintain communication and behavioral skills, and decrease family conflicts by "x" %.

Objectives:
1. Identify family conflicts by describing the nature, frequency and intensity of their conflict with each other from each family member's perspective.
2. Facilitate and develop healthy communication by expressing thoughts, feelings, and needs directly ("I statements), reduce misunderstanding and misinterpretations by at least "x" %, and improve conflict resolution skills.
3. Parents will develop, implement and administer a firm structure with a behavior modification plan using positive rewards to increase cooperative behavior.
4. Family members will create and implement a list of positive family activities that will enhance family harmony and increase emotional closeness by "x" %

Treatment will be done with all family member present, or combinations of family members, based on family need and clinical judgment.