The Definitive Report for Family Centered Treatment®

FAMILY CENTERED TREATMENT®

W.E Painter Jr., MS
L 'B' Smith, MS, LMFT
Revised 2014-T.J Wood, MS, LPC
Revised 2020 – W.E. Painter JR. MS

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History and Development

Family Centered Treatment® (FCT) was originally developed by the Institute for Family Centered Services (IFCS) with rights owned by the Family Centered Treatment Foundation, Inc.; a non-profit organization devoted to the furtherance of the field of family preservation. FCT is a model of treatment designed for use in the provision of intensive home based services. FCT origins derive from practitioners' efforts to find simple, practical, and common sense solutions for families faced with forced removal of their children from the home or dissolution of the family due to external and internal stressors and circumstances. Out of a desire and mission to create opportunity for change for families that were seemingly stuck in a downward spiral, grew a practice approach that was both distinct yet grounded, in the use of treatment components that were sound and research based. Although FCT is designed to address the operant issues of family functioning and societal required behavioral changes, a valuing changes process is integral to the FCT model. FCT can also be utilized with a variety of specialized need populations with behavioral, mental, and medical disorders where the family system has been impacted and is in need of support or change.

Since its inception in 1988 and as FCT developed, the model has maintained fidelity to the fundamental best practice standards / components for intensive in home services: (*Definition of Home Based Family Centered Treatment - Stroul, 1988).* These best practice standards are:

- Home based interventions represent the extreme on the dimensions of timeliness, accessibility, responsiveness and intensity.
- The intervention is delivered primarily in the family's home and community.
- Home based services have a family focus, and the family unit is viewed as the client.
- Services are provided in a natural setting. The services have an "ecological" perspective and involve working with the community system to access and coordinate needed services and supports.
- Home-based programs are committed to family preservation and reunification unless there is clear evidence that this is not in the best interest of the child.
- The hours of service delivery are flexible in order to meet the needs of families, and 24-hour crisis intervention is provided.
- Home-based services are multifaceted and include counseling, skill training, experiential interventions and helping the family to obtain and coordinate necessary services, resources, and supports.
- Services are offered along a continuum of intensity and duration based upon the goals of the program and the needs of the family.
- Staff has small caseloads to permit them to work actively and intensely with each family.
- The relationship between the home based worker and the family is uniquely close, intense, and personal.
- Home-based programs are committed to empowering families, instilling hope in families, and helping families to set and achieve their own goals and priorities.

- Home-based services utilize a range of research-based interventions, including crisis intervention, motivational interviewing, parent education, skill building, cognitive/behavioral therapy, Emotionally Focused Family Therapy and Eco-Structural Techniques.
- Interventions provide a point for change. Services reach families when they are in crisis. Client families in crisis are seen within 48 hours of referral.
- In addition to the best practice standards the following tenets are included as standard expectations:
  - Assessments are utilized which are engaging and put the family in charge of the process. FCT assessments reveal significant and relevant information about family functioning. This assessment process is designed to effectively engage families that have been previously characterized as resistant to services.
  - Services are based upon a tenet that troubled families can change.
  - Positioning families to give to others is an effective method for assisting the discovery of their innate dignity and worth.

The core practice components required by practitioners of Family Centered Treatment have evolved dramatically since the inception of the model in 1988. This has occurred because the key components of the model have been developed or integrated as front line practitioners' experiences precipitated changes or additions. While the methodology and process of FCT has many distinct aspects, the resulting primary components are simple and comparable to other evidence based models: Joining and Assessment, Restructuring, Valuing Change, and Generalization. Recent development includes the integration of Trauma Treatment designed to address the area of family functioning complicit to the complex trauma treatment components. The determination of the area of family functioning and complex trauma treatment needs are derived in part from the objective assessments of the Family Assessment Device and The UCLA PTSD-RI.

Integral to the development of FCT has been the management models utilized. Situational Leadership: Building Leaders (*The Center for Leadership Studies, 280 Towerview Court, Cary, NC 27513, Telephone 919-335-8763 | Fax 760-747-9384 | www.situational.com*), Helping others through Teamwork (Garner 2002) and have provided a method for peer and individual supervision that is consistent with the FCT values for practice. These management models emphasize a value of parallel process that can best be defined as: "Expecting of ourselves what is expected of families". In practice this process requires high accountability, adjustment of the style of leadership (therapy) based on level of development, and change theory. Without the thoughtful, intense, and positive confrontation that these management models integrate, FCT would not have developed.

Effective delivery of FCT is contingent upon a tripartite approach of management. All levels of management must support effective treatment over business pragmatism. This includes assuring that funding is in place for the:

1. Training to ensure that each direct service staff demonstrates theoretical knowledge and field skills competency
2. Fidelity measures built into the clinical process and the ensuing monitoring systems

3. Rigorous research and data collection systems

Practically speaking this means that FCT requires a commitment of management to provide:
- the intensive on line and field competency based training process; Wheels of Change© (over 95 hours of training),
- peer supervision via a weekly team meeting process designed for peer supervision,
- monthly staffing of each FCT case utilizing a family systems model of review (MIGS– mapping, issues, goals, and strategies)
- supervision to assure fidelity to the FCT model
- key treatment related documents that must be produced for each family provided services that are critical to each phase of FCT treatment and provide the hard documents to demonstrate fidelity to the model, and
- information management system that enables maintenance of a record review and tracking process necessary to assure maintenance of fidelity to the model for individual cases and for evaluation of outcomes in the aggregate.

Theoretical Basis

Family Centered Treatment is a comprehensive model that has developed over 30 years and has been refined based on research, experience, and feedback from practitioners and clients. Client response and feedback has been integral for defining what components of treatment have been effective. FCT is a model of practice that develops staff ability to prioritize and sort information to gain the underlying functions of behaviors within the family system. FCT, similar to other models of systemic treatment, is clinically structured to guide staff in determining what information requires attention and how to organize the information into a coherent narrative (Lindblad-Goldberg, 1998). Simply put, FCT theory provides the road map allowing staff to discover as they do the work with the family, "where they are and what to do next". Nevertheless FCT is not a predetermined and structured step by step model of treatment.

Although FCT has developed from applied success, some of the critical components are recognizable as derivatives of major models of evidenced based practice. Eco-Structural Family Therapy and Emotionally Focused Therapy provide the primary theoretical framework from which FCT has developed (Lindblad-Goldberg, M., 1998, Johnson, Sue., 2000).

The *Eco-Structural Family Therapy* model is based upon Minuchin's work (1981) and has been expanded by Aponte (1994), Szapocznik (2000), and Lindblad-Goldberg (1997) to incorporate the environment or larger social context of the family (Bronfenbrenner, 1977). The model most researched derived from the Eco-Structural agenda is the Brief Strategic Family Therapy (BSFT) (Szapocznik, 2000).[1] Eco - Structural theory is based on three basic principles.

- Approach for treatment is based on the family system. Family systems treatment is based on the belief that family members are interdependent: what affects one family member affects other family members. Significant to this point of view is the research demonstrating that families are

the strongest and most enduring force in the development of children and adolescents (Szapocznik and Coatsworth 1999; Bronfenbrenner, 1977).

- Patterns of interaction in the family influence the behavior of each family member. Patterns of interaction are defined as the sequential behaviors among family members that become habitual and are repetitive over time (Minuchin et al. 1967, 1981). Minuchin labeled this phenomenon as the structure of the family system.

- Interventions are designed that carefully target and provide practical ways to change those patterns of interaction (Szapocznik, 2000).

The other major theory that influenced the development of FCT is *Emotionally Focused Therapy (EFT)* (Johnson, 2000).[2] EFT is defined as a systemic model, relying heavily on *Structural Family Therapy* and particularly the practice of enactments. EFT has further developed the practice of enactments to expose or reveal the core emotional issues utilizing this information to enable and promote family attachment and bonds. This theory and practice is based on the belief that the most appropriate paradigm for family connection is that of an emotional bond (attachment) and that the key issue for family conflict is this bond. EFT treatment strategies are designed to facilitate accessibility and responsiveness created by emotional engagement, thereby developing the needed bonds from the process. The supporting theory for pursuing the emotional experiences in therapy, relies on the belief that these experiences result in the development of bonds that address the innate need for security, protection, and contact, as well as the ability to be independent and assertive (Johnson, 2000). Eco- Structural theory and Emotionally Focused Therapy rely upon changing the emotional tone and interactions of family members. Significant change can occur by altering the messages communicated in the process of the system interactions. Simply put, how families communicate is the primary focus of intervention.

Family Centered Treatment has incorporated the enactment process into all phases of treatment providing an opportunity for the family to utilize emotion to build attachments. Emotions are the key in organizing attachment behaviors and in organizing the way 'self and the other' are experienced in an intimate relationship (Johnson 2000). Both attachment and eco-structural theory stress the importance of emotional experience and expression. Emotional enactments guide and give meaning to perception, motivate to action, and provide a method for communication with others. They provide both a target and process for change in FCT. The creation of new emotional experiences through enactments is considered the most important factor in both intra-psychic and interpersonal change (Johnson, 2004). This process of guiding the family into practicing changes includes critical components for healing from traumatic experiences with the parents/caregivers becoming the key facilitators for the healing process for their family. Included in this distinctive approach for trauma healing is the ownership and apology to the family (a roles related need) by the caregiver/parent.

Additional influences for FCT have been derived from the peers helping peers models that focus upon effective connection and engagement based upon conveying a sense of worthiness, dignity, and respect. These core values drive practical behaviors required of staff and are necessary to form an effective therapeutic alliance (*Reclaiming Youth at Risk* (Brendtro, Brokenleg, and Bocken 1990, 2002).

Family Centered Treatment® components

Similar to many treatment models, FCT is focused into 4 main phases yet the emphasis upon value change is a unique aspect:

1. Joining and Assessment
2. Restructuring
3. Valuing change
4. Generalization

1 BSFT is recognized as evidence based practice by the following organizations: Strengthening Families (Exemplary II model); Blueprints for Violence Prevention (Promising Program); and Promising Practices Network (Screened Program).

2 EFT is recognized as a Promising Program by the SAMSHA National Registry of Effective Prevention Programs (Legacy Program).

Joining and Assessment Phase

The joining and assessment phase has some unique considerations. Family Centered Treatment grew out of practitioners' experiences based on effectiveness and success at a time when home based services were an anomaly. Initial referrals for service to IFCS (the agency that developed the model) were primarily the clients / families of the public and private sector that were known to have extensive histories of system involvement and failure as defined by the system. Development of an effective engagement process was crucial in order for the agency to remain viable and in business. The initial and principal skill needed by employees is effective joining and engagement. The joining portion of this phase is based upon a belief that connecting most occur before any correction can be effectively implemented. FCT incorporates methods for approaching families with dignity and respect regardless of history, needs, or station in life. Employees respond quickly to referrals, the very nature of a referral indicates that a family is in acute crisis and the family needs support quickly. Timely response to the referral also provides opportunity for engaging the family when they are more likely to be highly motivated to change and examine behaviors. Consideration for discharge begins with the initial contact incorporating a definition of successful discharge linked to the generalization of changed behaviors. FCT begins to assess from the first contact what skills are needed in order for a successful withdrawal from the family. Promises or "guarantees" are provided every family at the initial interview that are designed to demonstrate the recognition of the family's inherent dignity and differentiate FCT from their other service experience. clinician in executing this tenet, FCT assures that the service delivery will be intense and brief. The family problem serves to identify the needed skills instead of relying on professionals to do this assessment for them.

Often in-home treatment has been engaged as a last resort for a family that has already had many experiences with the system that have left them guarded and cautious. Therefore the joining and assessment phase of FCT requires a delicate balance of connecting to family members while challenging the way they operate (Lindblad-Goldberg, 1998, Robbins & Szapocznik, 2000). Highly skilled staff must disarm and join with a family to create an "ally" aspect to the treatment (Minuchin & Fishman, 2004). Joining is the process of coupling that occurs between the clinician and the family, leading to the development of the therapeutic system. In the process, the FCT clinician allies with family members by

expressing interest in understanding them as individuals and what is "working" for them and what is "not working" for them.

Joining is considered one of the most important prerequisites to restructuring. It is a contextual process that is continuous. Utilized in FCT are four methods in which structural family therapy joins with a family (Minuchin & Fishman, 1981, Lindblad-Goldberg, 1998).

   A. Tracking: In tracking, the clinician follows the content of the family by gathering information through using open-ended questions. Tracking is best utilized by the clinician observing the family pattern of interaction.

   B. Mimesis: The clinician becomes like the family in the manner or content of their communications style mimicking the family in these aspects.

   C. Confirmation of a family member: Using a feeling word to reflect an expressed or unexpressed feeling of that family member. For instance to say, "*Mom, when you say you want to be there for your children but you become angry at them when they come to you for assistance. You have allowed me inside your daily life and permitted me to see the anger you have at being bothered by them. Out of my respect to you I must be honest with you; this is giving your children a mixed message.*"

   D. Accommodation: The clinician makes personal adjustments in order to achieve a therapeutic alliance (Minuchin, 1974).

During the joining and assessment phase of FCT, a powerful set of assessment tools is utilized with both the family unit and individual members. This process provides the FCT clinician and the family with more information than has been previously revealed by other means. This process takes approximately 30 days to complete. The FCT assessment or *Family Centered Evaluation* (FCE) includes the Family Life Cycle (Carter and McGoldrick, 1989, Lindblad-Goldberg, 1998), the Eco-Map (Sherman & Friedman, 1986, Lindblad-Goldberg, 1998) and Genogram (McGoldrick, Gerson & Shellenberger, 1999). Patterns of family interaction that are repetitive and stable (the structure of the system) are the focus for identification the process that is maintaining the problem (maladaptive behavior). Family functioning is assessed by looking at dimensions of structure; the source of clinical formulation of the assessment phase. The experiential and validated assessments (FAD and UCLA PTSDRI) form the objective assessments that permit the family to determine the greatest areas of treatment need. These assessments when coupled with the more subjective evaluative components of the FCE merge the Complex Trauma Treatment Components with the Area of Family Functioning needs that will determine the treatment planning. This clinical formulation is shared with families as they go through each part of the Assessment process and the family makes the connection with their needs for change and the goals of treatment.

This "buy in" of the family in the treatment process often occurs during this participatory and experienced based assessment process. The FCE provides hope that they themselves can do something to help correct, prevent, or avoid the difficulties with which they have been challenged; a factor in change theory. This approach again differentiates the FCT model from other services and puts the family in charge of the process. If there is distortion, avoidance, or resistance to address honestly the real issues, the family is directed back toward addressing or "owning" the primary issues identified in the assessment process. Typically even families described as highly resistant to traditional services will honestly address their issues with clarity and develop appropriate goals when approached with respect and given opportunity

to identify the primary needs for change. Transition to the next phase of FCT is permitted as the family demonstrates their trust in the change process by their willingness to practice assignments, tasks, or suggestions developed in response to the initial needs identified In the Family Centered Evaluation. The assessment process is designed to engender trust in both the process and the clinician as the family recognizes that they are truly understood as they have shared their narrative and history via the assessment activities. In addition critical to movement from this phase is the recognition by the family that the work with them is about "all of the family" and not just one member. Their recognition that the family has changes to make in how they function lead to suggestions to practice a change in that now defined area of family functioning. The demonstration of the trust in the clinician and the process to try to implement or practice the suggestion is an indication for readiness for the next phase of FCT. This transitional indicator is built into FCT as a measure of treatment fidelity.

Restructuring phase

Goals determined during the *Family Centered Evaluation* provide the structure for guiding the family to develop the skills necessary to better negotiate the tasks associated with daily living that are congruent with the area of family functioning and complex trauma treatment needs they have identified. In the family system repetitive transactional patterns, which develop over time into "rules" of interacting, are often implicitly agreed upon around everyday life tasks. The irony is that the patterns remain long after the immediate developmental needs are met and they continue to govern future interactions and behaviors not related to current developmental needs (Minuchin, 1974). FCT interventions are targeted at shifting the repetitive interaction patterns that make up the structure of the family, (Minuchin, 1974, Minuchin & Fishman, 2004, Lindblad- Goldberg, 1998). This phase offers a unique way to set up *Enactments* (Minuchin & Fishman. 1981) that become experiential in nature (Minuchin, 1974, Simon, 1995). The process of enactment consists of families bringing problematic behavioral sequences into focus and inadvertently demonstrating them to the clinician in an experiential transaction (Minuchin, 1974, Minuchin & Fishman, 2004, Lindblad-Goldberg, 1998).

These are typically seen in daily living tasks that are based on operant issues of family functioning. The identified area of family functioning and the complex trauma treatment component become a road map for practicing new ways to meet the underlying needs that have come to the surface in behaviors that have prompted referral. These behaviors can be from the children or caregivers or both but FCT is focused on the underlying needs or functions rather than behavioral change. This process includes how a family handles conflict, their communication styles, and their ability to meet the family member's needs of affection, attention, and nurturing (Johnson, 2000). This process is especially suited for home-based therapy since the family is guided to continue doing things as usual and customary for them, thereby demonstrating for the clinician the dynamics of interaction at play. FCT enables observation of problematic interactions directly; rather than relying on stories about what happened "then and there". Families' stories of what has happened are often not accurate as all members' have their individual perspectives as to what actually occurred. The "here & now" witnessing of a pattern of interaction is far more effective in gaining valuable information to the dynamics of the family (Minuchin, 1974, Minuchin & Fishman, 2004, Lindblad-Goldberg, 1998, Szapocznik, 2000, Johnson, 2004). Once an interaction or family behavior is identified as an established pattern, the FCT goal is to move in and redirect the

interaction so that opportunities are created and available for the family to handle tasks and communication differently. In practice this occurs as a family displays behaviors that are counter to their chosen goals or are disruptive or dysfunctional, such as members yelling at one another or parents' withdrawal from their children. The FCT clinician, who has partnered effectively, is now permitted to provide guidance for suggesting changes to make. These suggestions are developed into intervention enactments designed to permit "practicing" new behaviors or responses to other's behaviors. As the family tries the suggestions the process leads to different outcomes. (Davis, S., 2004) The different outcomes are then processed and evaluated; a.k.a. highlighting. If the new outcomes are preferred, then the family is more likely to be able to repeat the interaction and therefore produce the same outcomes again as a result of the evaluation and processing components of the "sessions".

Replications of the changed behaviors or responses modify the system by creating a different structure for the family. This new structure provides the environment for healing from past traumatic events by developing for the family the physical safety (structural environment) and emotional safety (the permission for all feelings and recognition of the underling needs and functions of behaviors). FCT clinicians guide this process by pointing out the dynamics and sequencing of behaviors thereby drawing attention to the interactions. FCT provides opportunity for families to recognize patterns and identify changes in their individual behavior that they might make to bring about modification. As previously indicated, intervention enactments are designed relative to;

- the daily living tasks of family functioning, (Role Performance, Problem Solving and Affective Involvement)
- conflict resolution, (Behavioral Control)
- communication issues, (Communication)
- and how the family member's meet needs of affection, attention and nurturing.(Affective Responsiveness)

These situations or "events" occur naturally in the everyday moments of daily life. Utilizing these events, the clinician develops enactments designed to lead to different outcomes that in turn create change in the areas of functioning and structure and how they respond to the complex trauma coping skills developed by members.

This type of intervention enactment can be utilized to demonstrate for the family a way of doing the same task "differently" than they have done in the past and in a method that actually enables shifts in the family structure to occur. The result is that family members experience their own transactions with heightened awareness. In examining their roles, members often adapt to the new, more functional ways of acting (Simon, 1995, Minuchin & Fishman, 1981, Davis. S., 2004). In FCT this is defined further as the family is given suggestions/directions in how to "try out" alternative ways of interacting and then see how the outcome differs. This process enables a treatment approach that is experience based and allows family members to *feel* the interactions and outcomes. As feelings or emotions occur "in vitro" the changes and shifts in behavior happen more readily than via a cognitive didactic approach alone. It is during these daily tasks of living that development and maintenance of the nurturing bonds that keep a family close occurs (Bowlby, 1969, Greenberg & Johnson, 1988, Johnson, 2000). This provides a powerful opportunity to intervene in the "here and now" when the family is about to repeat their *typical* pattern.

When the change process is repeated and the family attention is emotionally allied with the changes and differing outcomes, the family can pick and choose the strategies that they feel most comfortable with that fit their cultural and personal identities (Minuchin & Fishman, 1981, 2004). Because treatment is done in the home/community this process permits a wide array of enactment possibilities that have been underutilized in traditional office based treatment. This method focuses upon the everyday behaviors with which people relate and connect and has come to be defined as eco-structural family therapy (Aponte, 1994, Minuchin & Fishman, 2004; Minuchin, 1974; Minuchin, Lee & Simon, 1996, 2006, Lindblad-Goldberg, 1997).

Repetitive *restructuring* (guiding new interaction) of family interactions shifts the structure of the family. The procedure of restructuring is at the heart of the structural approach, (Minuchin & Fishman, 1981, Minuchin, 1974.). Restructuring enables the family to become more functional by altering the existing hierarchy, boundaries, and power.

- Hierarchy is defined as who has the responsibility to care for whom, who dictates directions to others or authority (Minuchin, 1974). All families inherently have hierarchy within them. Alignment is defined via the emotional ties that bind together the members of the family.
- Boundaries identify who is included and excluded from this coalition (Aponte, 1994, Minuchin, 1974, Minuchin and Fishman 1981, Lindblad-Goldberg, 1998).
- Power is the influence family members have over each other in their effect on their behaviors or reactions (Aponte, 1994, Minuchin, 1974, Minuchin & Fishman, 1981).

The focus of interaction among the family members and with their community requires that FCT is processed oriented. Process orientation occurs when the family explores "what happens, when, and by whom". Process orientation also defines that the underlying message conveyed by this interaction (process) is more important than what was said among any two individuals (content). "Who reacts to whom, when, and so forth" provides the tracking of process within family interactions. Content is the concrete and specific facts used in communication and stops at that (Robbins & Szapocznik, 2000). *FCT relies heavily upon use of process to define the content changes that need to occur.*

Via the FCT, restructuring phase solutions for the family are developed in the natural occurring environment of the family. This eco-Structural approach assumes that the behavioral and emotional problems of individuals are maintained through patterns of interaction within the family and community (Minuchin, 1974, Minuchin & Fishman, 1981, Bronfenbrenner, 1977, 1979, Aponte, 1994, Lindblad-Goldberg, 1998). The goal of treatment is to alter these interaction patterns to change the behaviors and emotional interaction of the individual members by introducing new patterns (Minuchin, 1971, Minuchin & Fishman, 1981, Calapinto, 1983, 1991). FCT utilizes a fidelity tool of family systems case review or staffing process known as Map, Issues, Goals, Strategies or MIGS (Edwards, 2003) that effectively incorporates the eco-structural theory.

Transition to the next phase occurs as the family develops the ability to identify and target behaviors for alteration of their own choosing. The need for transition in the treatment approach of the FCT clinician becomes apparent as the family decides that they would rather utilize enactments to address a behavior(s) that they have identified as a dysfunctional pattern rather than continue to follow the lead of

the FCT clinician. This is an indication that the family is ready for developing effective new behaviors or to modify previous behaviors in order to find solutions to problematic "events" (rather than defining them as crisis). This permits the FCT clinician to provide direction by extrapolating options based on past "work". As the family becomes less dependent upon direction and suggestions and is practicing the changes in functioning and responding to trauma coping behaviors differently, the FCT clinician begins to adjust from giving direction to asking questions that cause the family to look at why they are making the changes and evaluate on their own if they are functioning more effectively. This request is identified as a transitional indicator and becomes a fidelity measure of FCT.

Valuing Change Phase

Valuing change is a critical component of FCT developed to permit the family system to identify the new "practiced" behaviors that they value. Valuing change is integrated into FCT so that changes are not made simply, to get through a crisis, in response to directions by the FCT clinician, or in order to conform or comply with the external system.

The valuing change phase begins when the family starts having some success with the behavioral changes they've made. They begin to feel good and experience some pride in how they're handling the tasks of daily living. Troubling behaviors begin to decrease and negative patterns become the focus rather than focus upon individual incidents or "crisis". Although many treatment models interpret this change as a definition of success and reason for closure, FCT defines this change in functioning as performance based and justification to adjust the therapeutic process, not the "end' of treatment.

For families in treatment a desire to maintain these altered behaviors "after" services or treatment has ended does not naturally occur. This is understandable because change is "hard work" and while families or members can "go along with" or tolerate temporary changes, long term adjustment may seem overwhelming to continue. Resistance may now be exhibited by one or more family members that have "performed" the changes while not valuing them. They would prefer to return to the previous methods of functioning and structure. Their reasons are idiosyncratic.

In other situations this resistance is not a function of a desire for maintenance of the current system, but is caused by intense emotional pain related to past (time lapse is irrelevant) events that have traumatized one or more family members. These traumatic experiences may inhibit the individual's or family's ability to try new behaviors or accept new or adjusted roles. Often resistance occurs during this phase as the underlying and "painful" histories of hurt and harm interfere with the ability of the entire family system to internalize these new found behaviors. Again there is a function to the behaviors previously utilized. When such is the causality for not being able to internalize or enact new behaviors the desire to change may be present but the freedom to do so may be lacking. Often redirection back to the restructuring phase will need to occur. When such is required, the clinician utilizes the techniques described in the Restructuring Phase with added awareness and emphasis on understanding and changing behaviors that have been habituated as a result of past trauma. During this phase or at the 3-month juncture in treatment, the utilization of the FCE components including the trauma assessments provide revisiting now as treatment tools rather than evaluation alone. The family has opportunity to determine or "own"

the changes made as they evaluate the differences in individual member's and family functioning from the initiation of services to the present. The connection with the awareness of the needs that were prompting the troublesome or referral behaviors is critical during this phase in order for sustainability of the progress in functioning. Additional needs for healing from trauma are explored as the family revisits the participatory activities that were part of the initial evaluation process.

Methods for creating valuing change occur as the FCT clinician utilizes intense interventions, escalation of stress, manipulation of the family mood, symptoms technique, assignments, paradoxical injunctions, boundary marking, and support approaches (Minuchin, 1971, Minuchin & Fishman, 1981, Calapinto, 1983, 1991).

- FCT relies upon intense intervention to provoke structural change (Minuchin, 1974). Intensity is the structural method of changing maladaptive transactions by using strong affect, repeated intervention, or prolonged pressure. Intensity works best when the clinician knows what they want to say and can do so in a direct unapologetic manner that is goal specific. This permits the family to grapple with a specific sequence of interactions and adjust or change them until there is some level of resolution. This can take place by prolonging the interaction and as the family gets higher levels of anxiety, they will eventually interact differently with a different outcome (Minuchin & Fishman, 2004, Johnson, 2004).
- Escalating stress is a slightly different technique utilized by FCT. Escalating stress, the clinician can encourage conflict until the stress mounts and the family members act differently in novel ways which produce alternative outcomes or the clinician can block dysfunctional interaction patterns that serve to reduce stress resulting in an alternative outcome (Minuchin, 1971, Minuchin & Fishman, 1981).
- Another method of FCT is the manipulation of the family mood. This process occurs as the FCT clinician attempts to change the pace or tone of the session by introducing various activities that engage family members in different ways and offer an opportunity for them to interact differently. This has the effect of often changing the mood toward one another (Minuchin, 1971, Minuchin & Fishman, 1981).
- In use of symptoms technique FCT provides opportunity for the function (reason behind or underlying the behaviors) of the system take on a different meaning so the effect is therefore also changed. Encouraging the symptom, de-emphasizing the symptom, or reframing the symptom is all examples of ways to achieve this effect (Minuchin, 1971, Minuchin & Fishman, 1981, Haley, 1987).
- Task assignment is an FCT process specific to different family members or subsystems whereby the clinician can also alter the function of a symptom. When resistances to suggestions are displayed in the predictable interaction patterns, the clinician can use paradoxical injunctions. A paradoxical injunction places the family member in a double bind so that regardless of how they react, resist, or comply, change will be promoted (Minuchin, 1971, Minuchin & Fishman, 1981).
- Marking boundaries is a method for the FCT clinician to assist the family in setting new boundary rules or renegotiating old rules. Specific functions of each subsystem are used to strengthen, diffuse, or soften rigid boundaries (Minuchin, 1974, Minuchin & Fishman, 1981).

- Support Techniques are guidance and psycho-educational instructions the FCT clinician uses to teach a family to behave differently and identify why this change will impact their lives. This method is typically used with the authority executive subsystem in the family (Minuchin, 1974).

In addition, FCT employs established and recognized therapeutic approaches to "challenge" this dynamic while emphasizing recognition of the "right" of the family system to "choose" their path.

Some of these commonly recognized therapeutic approaches are:
- Paradoxical Injunctions
- Sculpting
- Empty Chair
- New Talk
- Alter Ego
- Developing Discrepancies
- Reframing
- Attachment Needs.

These techniques provide a vehicle for creating value conflict when a family system or members are at this juncture. The intent of this process is to empower the family as a unit to make informed decisions about what changes to keep and understand why they are choosing to do so. The change process incorporates guiding the family to identify alternatives to the changed behaviors that they have learned or practice and freely choose the alternative they want as a system after thoughtful consideration of the consequences of each alternative. FCT prizes or prioritizes the family being happy with the choice and asks them to willingly affirm the choice publicly with their external support system and referral source; as appropriate. The final aspect of this phase is guiding the family to "do something" (emphasis on action) with the choice and adjust the pattern of family life accordingly. Within this phase of FCT, part of this doing something involves a power of giving project designed to give back to the community or others in need while capitalizing upon strengths or skills identified as part of the determination of changes they want to keep as a family system. The family's completion of this idea or request becomes a fidelity measure for this phase of FCT.

Specifically, FCT clinicians adjust their style of treatment during the Valuing Change phase in order to facilitate value conflict and change by:
- Building the family's confidence by guiding them to see that they have the ideas, answers, suggestions, and insight that will work.
- Lessen the frequency and duration of sessions involved while continuing to closely monitor activities and results.
- Guiding the family to determine the focus of the family "meetings" (sessions) and let them direct the process.
- Reflecting concerns and questions back to the family system – not necessarily back to the one with the concern or question, but nevertheless back to the family system.

- Engaging the family, especially the parent(s), in "giving back" activities--teaching or using what they know with others and making this giving back project one that highlights their newfound ways of functioning that previously of concern
- Reminding the family of their history, the changes they've made, and the successes brought by those changes
- In revisiting the FCT evaluation components including the formal objective assessments of the FAD and PTSD-RI and reviewing the tape of the initial Structural Family Assessment the family sees the changes they have made and own their success.

FCT clinicians are cautioned to fastidiously bring all issues back to the family session. A priority of this phase is to avoid the myth of confidentiality that excludes the family members that may need to be involved in the problem solving process.

In summary the Valuing Change phase of FCT guides the family to examine the values that dictate the choices they make after they have learned to behave differently in handling the aspects of daily living and functioning that they initially identified. By experiencing different outcomes, an opportunity to change their value structure is revealed. This process provides an opportunity for examination of their choices; pointing out that they can choose the behaviors that will make lasting changes that will survive beyond the treatment process. This change in family functioning and shift in structure will help to ensure that the family is a healthier unit as a whole compared to the beginning of treatment permitting all its members to benefit from these improvements. This shaping competence is a way for families to build upon what they already have and access resources which were previously underutilized (Minuchin & Fishman, 1981, 2004 & Lindblad-Goldberg, 1998). Demonstrating the ability to more consistently provide the physical and emotional safety necessary for the on-going process of healing from past traumatic events is an indicator that the family is ready for transition towards closure or lesser intense form of services.

Transition to the Generalization Phase occurs as the family begins to demonstrate the ability to handle crisis or difficult to handle events on their own with little oversight and direction from the FCT clinician. Their identification of this change in their functioning becomes an indicator for transition and part of the FCT fidelity measures.

Generalization phase

An indication of the family's readiness for transition to the Generalization phase occurs as they share with the clinician what they did as opposed to asking what to do. Typically a family that enters this stage of treatment is no longer overwhelmed by the crises or circumstances that tend to lead to crises. Instead they are handling them with their new skills and reporting the outcomes to their clinician.

During the Generalization Phase the FCT clinician adjusts the style of treatment once again. As the family effectively manages situations or circumstances that would have previously developed into a crisis, the FCS highlights what "they (the family) did", reminds them that they "did it on their own", and explores how they can use the same process in other crises or challenges in their lives. During this phase the FCS guides and directs the family to keep trying different strategies to resolve crises until they happen upon

a strategy that works. A paradigm shift occurs as the family experiences that "failures" are part of the "progress". This value is one that FCT seeks to "leave" internalized by the family.

This phase, once recognized, should only last 30 days, with a rare exception to 60 days. (I.e. when a court date or anniversary event is scheduled after 30 days the case may remain open beyond the 30 day period). FCT's definition of a "good" and appropriate closure is not determined by a source that's external to the family. While theory dictates that the family and other stakeholders of the treatment process determine when services close, in practice, most models of treatment end when families merely conform to external demands, or are resistant to external demands, or funding limits are reached.

Instead FCT works with the family to determine the timing of closure, using an analytical process that evaluates the changes that have occurred and the family's ability to use the strategies independently of external agencies. Integral to the FCT model is the previously described value change phase designed to assess the family's ability to function effectively independently of external agencies control or daily direction. This assessment does not occur for models of treatment that end services when behaviors have changed due to conformity or compliance to external demands.

The FCT clinician works to ascertain the function of the family's request for termination of services. The closure evaluation process contains many similarities to the Family Centered Evaluation process that occurs during the Joining and Assessment phase.

FCT integrates intervention enactments to effectively work with families desiring closure but for whom the changes needed have not occurred or for whom the changes have not become internalized. This process incorporates procedures designed to place the family into value conflict if the changes needed at initiation of services have not occurred for them. When the family requests a continuance of services in response to the intervention they are asked to define their need and in written form affirm their desire for a continuance of services. Emphasized throughout the process is the right to self-determination as a family unit (as such relates to service provision). Again a hallmark of FCT is the emphasis upon respect and dignity throughout the process. The specific behaviors that the family needs to change for services to continue depend upon the situation; however, there are some key tenets that the FCT clinician utilizes during this intervention process:

- FCT always presents the need for change as an option/alternative, not an order or requirement.
- FCT respect the family's right to choose and control their life – give dignity to this power whenever possible.
- FCT reminds the family that while the consequences may seem intolerable for them, the real issue is the family's lack of motivation for change.
- FCT explains for the family that superficial conformity or compliance, while okay for early stages of the treatment process, does not create the long term change needed.
- FCT always asks the family to respond to the initial statements of the clinician that the process is not working.

When the family has *generalized* the behaviors needed they are ready for ending FCT services. A key indicator of the family system's success is that the family does not identify individual family members or

external factors as the cause of the initial problems during the closure evaluation. They identify what they themselves are doing differently to make family life work better and they identify and implement these changes without the clinician guiding them to do so.

Critical activities in this phase include planning for the future with an intimate awareness of the areas of functioning of difficulty that have preciously led to system involvement and identification of the trauma bonds that have triggered the ineffective family functioning. This awareness, although expressed in common sense behavioral terms, provides opportunity for rewriting the trauma narrative. Clinicians reengage the family in practicing / roleplaying responses to the predictable life events of family life cycle and child development as well as practicing responses for the unpredictable life events that are connected to their worst fears.

In addition as they transition out of this phase they begin to challenge and remind each other of the new approaches that they have developed to manage relevant needs or concerns related to communication, conflict, the tasks of daily living, and the behaviors they utilize to meet needs for closeness, attention and affection. As the family identifies these new approaches for handling predictable and unpredictable future events they become an indicator for closure and are identified as a fidelity measure of this phase of FCT.

Integral to the transition from generalization to closure of FCT services is the family celebration. FCT emphasizes the family system as the source for change and any success gained, not the clinician or the agency.

In summary, Family Centered Treatment (FCT) centers treatment on the family system. The four phases of treatment; Joining and Assessment, Restructuring, Value Change, and Generalization provide the structure for treatment with the ability to move back and forth based on the function of the behaviors needing adjustment. FCT clinicians are taught and supervised with a model of management that requires adjustment of the therapeutic approach to be utilized in correlation with the phase of treatment.

The basic framework for treatment draws from components of Eco Structural Family Therapy and Emotionally Focused Therapy. FCT includes unique assessment tools, an emphasis on connecting before efforts are made to correct behaviors, and a distinctive values internalization phase.

Family Centered Treatment provides a family system's model of treatment focused on behavioral change for the members of the system and can be utilized with many specialty populations. Family Centered Treatment requires involvement of a family system, however "family" is defined (e.g., can be composed of non-related individuals living together as a family system). In addition, the primary focus of the treatment model is not psychiatric or medical. Nevertheless, FCT can be utilized effectively when illnesses, either medical or psychiatric, are affecting the short or long term functioning of the family system.

The Four Phases of Family Centered Treatment®

Joining and Assessment

During this phase the clinician engages the family and gains acceptance and trust. The family centered evaluation is utilized to determine areas of family functioning that need adjustment.

Indicator for Transition: The family begins to carry out the clinician's suggestions and assignments indicating trust in the process.

Restructuring

The clinician and the family use enactments (experiential practice experiences) to alter ineffective behavioral patterns among family members. This process includes techniques to modify the crisis cycle to more effective and adaptive patterns of family functioning. If emotional blocks, due to past or present trauma, prohibit compliance with practicing new behaviors, the clinician engages the family or specific members into trauma treatment, via emotion change techniques, rather than behavioral approaches.

Indicator for Transition: Successful enactments lead to earnest questions by the family members regarding what they can do differently to change/break their maladaptive patterns. These questions are an indicator that the ownership of problems is now seen as a family issue, rather than placing the blame on an individual family member. When the practicing of new interactions begins to produce behavioral changes, the clinician moves to the next phase.

Emotional Blocks / Trauma Treatment

With clinician guidance, the family determines coping and supportive behaviors to address traumatic histories. They are guided to identify and practice effective methods for meeting emotional needs.

Valuing Changes

The clinician adjusts their style and methods in order to challenge the intent and reason for the behavioral changes that the family has made. The family evaluates and defines the reasons for their changes. Family members integrate new behaviors into their personal value system, determining changes to sustain based on what is working for them.

Indicator for Transition: The family is no longer merely conforming or complying with directions, but is following through on suggestions and expanding upon them to meet their own needs. Although crisis may still continue, the family tells the clinician how they handled the situation using their newfound skills, rather than asking the clinician what to do.

Generalization

With new skills for dealing with conflict and increased understanding of their own dynamics, the family continues its work, but the treatment is less intense and frequent. The clinician's focus is continued "practice", review of what has "worked" previously, and use of "reversals."

Indicator for Transition: New skills have become internalized and new responses to crisis are becoming patterns. Once in this phase the family will be ready for discharge within 30 – 60 days.

Fitting it all together
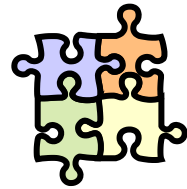
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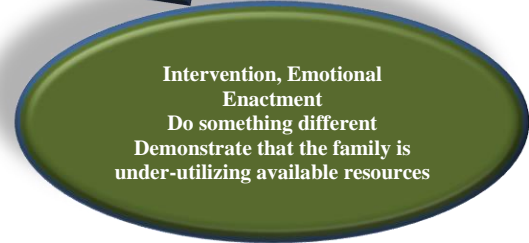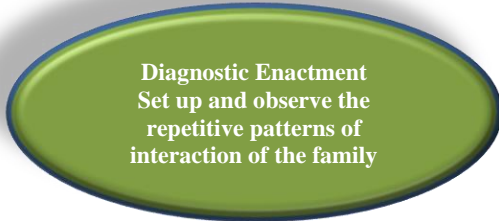**Family Therapy**
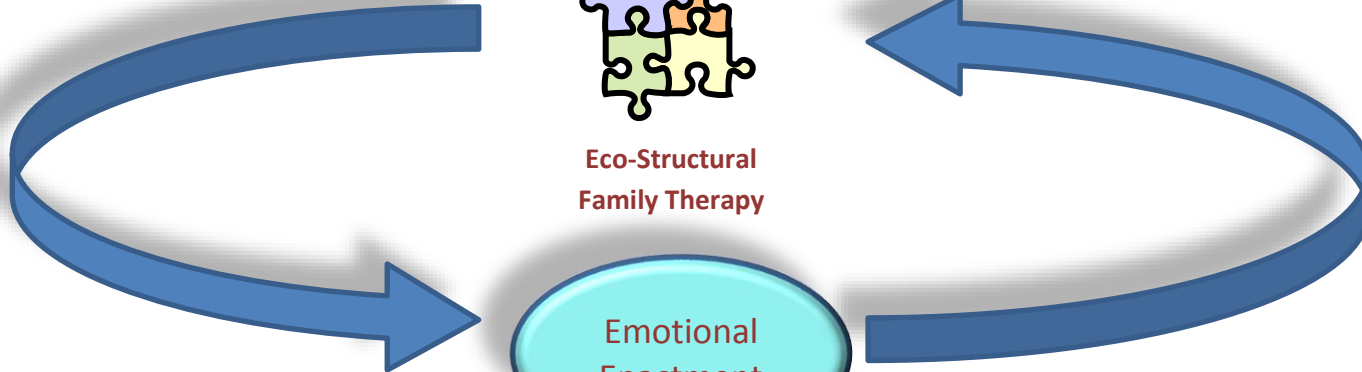
Situational
Leadership
Model

Conformity
forced by social
control Vs.
Internalized
Values

Therapy

**Emotional
Enactment**

One
Interaction/Slice of
time, a snap shot

**Time Line – Family Life Cycle
Intergenerational Theory**

**Techniques:
Solution Focused,
Strategic,
Intergenerational,
Narrative,**

Highlight alternative outcomes

**Diagnostic Enactment
Set up and observe the
repetitive patterns of
interaction of the family**

**Intervention, Emotional
Enactment
Do something different
Demonstrate that the family is
under-utilizing available resources**

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