

RESEARCH SUPPORTING STRUCTURAL FAMILY THERAPY

In 1999 the Administration at Daytop (Mendham Inpatient Site) contracted with the Minuchin Center to train their staff in family therapy, and facilitate the development of a more family friendly agency.

Some of the findings of the initial assessment before training were:

1. The clinical staff was primarily practicing individual treatment. Their contact with the family was erratic, and was mainly to pass on information about the adolescent in treatment. The therapists voiced frustration with the families "lack of involvement."
2. Upon admission the agency assumed control of the contact between family and adolescent. The families were to attend family association meetings on a monthly basis. The administration had just mandated parental participation at these meetings due to low attendance. There were attempts to conduct family sessions, but often there would be a long lapse between admission and the first family meeting.
3. The parents were often frustrated with their lack of knowledge about their children. Many felt out of "the loop" and helpless. There was a strong concern about the lack of academic education and training during their child's treatment.
4. The rate of successful completion was 23%.

At the end of 2003 after a three-year consultation, there were many positive changes in this agency. Some of the major ones are:

1. All clinical staff has been trained in a family systems approach. Family therapy is an ongoing treatment modality both inpatient and in the outpatient clinic. Supervisors were further trained in family systems to provide supervision and ongoing training for new incoming staff.
2. The intake process was changed so that the family is involved from the beginning.
3. Family therapy is a strong factor in the adolescent's treatment.
4. The Family Association is very independently active and has expanded to four sites around the state; this is to facilitate attendance for parents who live hours away from Mendham.
5. There is a quality education program in place for adolescents.
6. The rate of successful completion has risen to 46%.

POPULATION – SUBSTANCE ABUSE/ADDICTION

In recent years there has been a steady accumulation of research on family-based interventions for substance abuse. Stanton and Shadish (1997) concluded, from their meta-analysis of family therapy for drug abuse, that family therapy with adolescents show better results than non-family approaches. Other reviews also recognize family-based treatments as among the most promising approaches for the treatment of adolescent drug problems (Williams & Chang, 2000; Winters, Latimer, & Stinchfield, 1999). This makes sense in that considerable research suggests that family management practices are a variety of risk factors associated with adolescent substance abuse (Hawkins, Catalano, and Miller, 1992).

In 1982, Stanton and Todd used structural family therapy techniques in their study on family therapy and drug abuse/addiction. Their study found that structural family therapy was significantly more effective than non-family therapy approaches. Structural family therapy continues to be the basis of family work done with this population (www.SAMHSA.gov). Hendrickson and McCollum speculate this model is still embraced in this area, due to the chaotic nature of families where one or more family member is addicted or abusing substances, and the need for increased family functioning.

Stanton and Todd focused on the client – parent (caregiver) dynamic. This model assumes that developmentally the individual and parents are stuck in a “launching phase” and the abuse of substances helps maintain this dynamic. They would employ typical structural techniques to establish boundaries between the client and his/her parents and to strengthen the couple. Treatment goals included abstinence from substances, productive use of time, and independent living.

Due to family dysfunction and symptomatic behavior, teenage drug abusers can be difficult to engage and retain in treatment. Family dysfunction is connected to various adolescent problem behaviors. These behaviors make providing adequate services a challenge. With family-based approaches clinicians have the advantage of addressing some of the very barriers that keep troubled youth from getting the help they need (Stoolmiller, Duncan, Bank, & Patterson, 1993; Prinz & Miller, 1994; Kazdin, Holland, & Crowley, 1997; Coatsworth, Santisteban, McBride, & Szapocznik, 2001). Szapocznik and Williams (2000) continued to refine engagement techniques using three core structural family therapy strategies: joining, family pattern diagnosis, and restructuring. These studies have shown that these techniques successfully retain families and produce effects, even among severe cases.

Coatsworth, D., Santisteban, D. McBride, C. & Szapocznik, J. (2001). Brief Strategic Family Therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process*, 40(3), 313-332.

Hawkins, J., Catalano, R., Miller, J. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin* 112, 64 – 105.

- Kazdin, A., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, 65(3), 453-463.
- Prinz, R., & Miller, G. (1994). Family-based treatment for childhood antisocial behavior: Experimental influences on dropout and engagement. *Journal of Consulting and Clinical Psychology*, 62(3), 645-650.
- Stanton, M. (1981a). An integrated structural/strategic approach to family therapy. *Journal of Marital and Family Therapy* 7 (4): 427-439.
- Stanton, M. (1981b). Strategic approaches to family therapy. In: Gurman, A., & Kniskorn, D., eds. *Handbook of Family Therapy: vol I*. New York: Bruner/Mazel, pp. 361 – 402.
- Stanton, M. (1984a). Breaking away: The use of strategic and Bowenian techniques in treating an alcoholic family through one member. In: Kaufman, E., ed. *Power to Change: Family Case Studies in the Treatment of Alcoholism*. New York: Gardner Press, pp. 253-266.
- Stanton, M. (1984b). Fusion, compression, diversion, and the working of paradox: A theory of therapeutic/systemic change. *Family Process* 23 (2): 135-167.
- Stanton, M. (1988). Coursework and self-study in the family treatment of alcohol and drug abuse: Expanding Heath and Atkinson's curriculum. *Journal of Marital and Family Therapy*. 4(4): 419-427.
- Stanton, M. (1997). The role of family and significant others in the engagement and retention of drug-dependent individuals. In: Onken, L., Blaine, J., and Boren, J., eds. *Beyond the Therapeutic Alliance: Keeping the Drug Dependent Individual in Treatment*. NIDA Research Monograph 165. NIH Publication No. 97-4142. Rockville, MD: National Institute on Drug Abuse, pp. 157-180.
- Stanton, M. & Shadish, W. (1997). Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin* 122 (2): 170-191.
- Stanton, M., Todd, T., et al. (1982). *The Family Therapy of Drug Abuse and Addiction*. New York: Guilford Press, 1982.
- Stanton, M., Todd, T., Heard, D., Kirschner, S., Klieman, J., Mowatt, D., Riley, P., Scott, S., and Van Deusen, J. (1978). Heroin addiction as a family phenomenon: A new conceptual model. *American Journal of Drug and Alcohol Abuse* 5(2): 125-150.

Stoolmiller, M., Duncan, T., Bank, L., & Patterson, G. (1993). Some problems and solutions in the study of change: Significant patterns in client resistance. *Journal of Consulting and Clinical Psychology*, 61(6), 920-928.

Substance Abuse and Mental Health Services Administration. *Substance Abuse Treatment and Family Therapy: A Treatment Improvement Protocol: TIP 39*. www.samhsa.gov

Szapocznik, J., & Williams, R. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review*, 3(2), 117-134.

Williams, R., Chang, S. (2000). A comprehensive review of adolescent substance abuse and treatment outcome. *Clinical Psychology: Science & Practice*, 7, 138-166.

Winters, K., Latimer, W., & Stinchfield, R. (1999). The DSM-IV criteria for adolescent alcohol and cannabis use disorders. *Journal of Studies on Alcohol*, 60, 337-344.

POPULATION – GENERAL, ADOLESCENTS

Due to the important role families' play in the social and emotional development of children, family-focused interventions are an important piece to child and adolescent mental health treatment. Controlled trials have shown the effectiveness of family-based interventions for physical child abuse and neglect; conduct problems; emotional disturbance; and psychosomatic concerns.

Treatments are typically short-term, outpatient, and have cognitive-behavioral, structural, or strategic foundations (Shadish, Montgomery, Wilson, et al., 1993; Carr, 2000).

Carr, A. (2000). Evidence-based practice in family therapy and systemic consultation: I. child focused problems. *Journal of Family Therapy* 22: 29-60.

Goldstein, M. & Miklowitz, D. (1995). The effectiveness of psychoeducation family therapy in the treatment of schizophrenic disorders. *Journal of Marital and Family Therapy*, 21, 361-376.

Markus, E., Lange, A., & Pettigrew, T. (1990). Effectiveness of family therapy: A meta-analysis. *Journal of Family Therapy*, 12, 205-221.

Shadish, W., Montgomery, L., Wilson, P., et al. (1993). The effects of family and marital psychotherapies: a meta-analysis. *Journal of Consulting and Clinical Psychology*, 61, 992-1002.

Shadish, W., Ragsdale, K., Glaser, R., & Montgomery, L. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy*, 21, 345-360.