Contemp Fam Ther (2013) 35:147–160
DOI 10.1007/s10591-012-9224-4

ORIGINAL PAPER

Ecosystemic Structural Family Therapy: Theoretical and Clinical Foundations

Marion Lindblad-Goldberg · William F. Northey Jr.

Published online: 3 January 2013
© Springer Science+Business Media New York 2012

Abstract Ecosystemic structural family therapy (ESFT) is a systemic, strength-based, and trauma-informed family therapy model that has evolved from structural family therapy (SFT; Minuchin in Families and family therapy, Harvard University Press, Cambridge, 1974). ESFT is an evidenced-based family therapy approach designed to intervene with families of children who are experiencing behavioral health problems and are at the risk of out-of-home placement. In this article we review the theoretical, applied, and empirical evolution of ESFT relative to extant SFT models. ESFT is based on the fundamental assumption that child, parental, and marital functioning are inextricably linked to their relational environment. Five interrelated constructs guide ESFT therapists in their understanding of clinical problems: family structure; family and individual emotional regulation; individual differences (e.g., historical, biological, cultural, developmental); affective proximity; and family development (Gehart 2010). ESFT has an extensive evaluation history dating back to the 1980s involving over 4,000 families in 39 different sites. While ESFT is considered evidence-based, it might be more consistent with "Practice-Based Evidence" given its long, extensive, and successful, history in the child mental health system in Pennsylvania.

Keywords Ecosystemic structural family therapy · Structural family therapy · Family therapy · Clinical interventions · Evidence-based models · Practice-based evidence · Child mental health

M. Lindblad-Goldberg (✉)
Philadelphia Child and Family Therapy Training Center, Inc., P. O. Box 4092, Philadelphia, PA 19118-8092, USA
e-mail: marionlg@philafamily.com

W. F. Northey Jr.
N-P Consulting and Therapeutic Services, Wilmington, DE, USA
e-mail: northey@comcast.net

Introduction

Effectively intervening with the families of children with serious emotional disturbance (SED) has long been a goal of communities (Hansen et al. 2002). The provision of services in the homes of children in crisis dates back to the turn of the twentieth century with the inception of the child guidance movement and social services (Lourie 2000). However, there was a dramatic shift, both in service settings and orientation of problems, with the primacy of psychoanalytic psychotherapy and the concomitant focus on the inner worlds of children (Woods 1988). The pendulum again began to shift in the 1960s and 1970s as family therapy emerged as an alternative treatment modality in many outpatient settings (Hansen et al.). One of the most utilized and widespread family therapy models was Structural Family Therapy (SFT; Minuchin 1974; Minuchin and Fishman 1981). This article focuses on the theoretical, applied, and empirical evolution of an extant SFT model designed to assist families who are struggling with children dealing with SED, specifically ecosystemic structural family therapy (ESFT).

ESFT is an empirically supported adaptation of SFT (Gehart 2010). This evidence based model was developed by Lindblad-Goldberg in the late 1970s and elaborated upon beginning in the 1980s with continuous improvements promulgated to date by Lindblad-Goldberg and her colleagues at the Philadelphia Child and Family Training Center (formerly the Philadelphia Child Guidance Clinic; Gehart 2010; Jones and Lindblad-Goldberg 2002; Lindblad-Goldberg and Jones 2005). The ESFT model targets treatment for children and adolescents with moderate to severe emotional and/or behavioral problems and their families in outpatient settings (Lindblad-Goldberg 1986, 2006; Jones and Lindblad-Goldberg 2002) and in-home/community settings (Lindblad-Goldberg et al. 1998, 2004).

Theoretical Foundations

The ESFT model is integrative with respect to its theoretical foundations and has been stimulated by advances in theory and research from myriad fields. ESFT is firmly grounded in both family systems theory (Becvar and Becvar 1982) and SFT as explicated by Minuchin and his colleagues (e.g., Minuchin 1974; Minuchin et al. 1978; Minuchin and Fishman 1981; Elizur and Minuchin 1989; Minuchin and Nichols 1993; Fishman 1993). As Jones and Lindblad-Goldberg (2002) point out, Jay Haley had a significant influence on the development of SFT specifically given his intimate involvement with the MRI group and their focus on communication and systemic theories (e.g., Bateson 1979; Haley 1987; Jackson 1957; Watzlawick et al. 1967). It is beyond the scope of this paper to detail the history of SFT (cf., Colapinto 1991; Minuchin and Nichols 1993; Nichols and Schwartz 1998) and how it relates to ESFT, but the theoretical assumptions promulgated by ESFT developers are clearly steeped in the tenets of systems theory and SFT:

- All behavior is a form of communication within a defined cultural context.
- Symptoms occur within the context of social interactions.
- Causality is a circular, not linear, phenomenon.
- Families are evolving multibodied systems that continually regulate their internal structure, rules and roles in response to developmental and environmental changes.
- Adaptive functioning is determined by the fit of a family's structure to the functional demands made upon it from within and beyond the system.

- Family members relate to each other in patterned ways that are observable and predictable.
- Repetitive patterns created by family roles and rules evolve in an interlocking, complementary fashion.
- Family members develop a preferred degree of emotional and functional levels of proximity and distance in relating to one another.
- Families are hierarchically organized, with unwritten rules for interactions between and within the subsystems.
- Inadequate hierarchical structure and boundaries maintain symptomatic behavior.
- Family patterns are replicated in the surrounding ecosystems.
- Individuals are inherently competent, although rigid interactional patterns can inhibit the expression of that competence.
- Change in family structure contributes to change in the behavior of individual members.
- Promoting alternative transactional patterns broadens the flexibility and competence of individuals and subunits in the family and its ecosystems.
- Families are their own best resource for change (Lindblad-Goldberg et al. 1998, pp. 25–26)

As with other variants of SFT (e.g., Brief Strategic Family Therapy [BSFT; Szapocznik and Williams 2000], Multidimensional Family Therapy [MDFT; Liddle 2000], Attachment Based Family Therapy [ABFT; Diamond et al. 2002], Multisystem Therapy [MST; Henggeler et al. 1998], and BioBehavioral Family Model [BBFM; Wood et al. 2000]), ESFT maintains the focus on family structure (i.e., boundaries, subsystems, rules) and enactments (Gehart 2010). While the foundational aspects of SFT have been maintained by the various versions of SFT, many have incorporated emerging research and knowledge about families to modify and improve the delivery of SFT in a multitude of clinical contexts.

One of most significant modifications to ESFT has been the inclusion of attachment theory as an organizing principle in the model with an increased focus given to individual and family attachment and emotional processes. Attachment theory has become ubiquitous in the couple and family therapy literature for myriad clinical issues both in children and adults (e.g., Byng-Hall 1991; Johnson 1996; Marvin and Stewart 1990) Attachment theory has become a core component within three of the major SFT variants, including ABFT (Diamond et al. 2002), MDFT (Liddle 2000) and BBFM (Wood et al. 2000). As Jones and Lindblad-Goldberg (2002) explain, there is considerable developmental research supporting the critical role played by security of attachment in both psychological and behavioral outcomes. Additionally, Lindblad-Goldberg and her colleagues have noted the direct effects of trauma on relationship behavior and the resulting influence on the way that people experience attachment within families. A significant number of caregivers and their children with SED have histories of complex traumatic stress and loss which account for the attachment disruptions and emotional dysregulation among all family members (Van der Kolk 2005). Complex traumatic stress creates sustained autonomic nervous system arousal, generating perceptions of physical and/or emotional risk which can limit the development of adaptive emotion regulatory skills and exacerbate pre-existing biological vulnerabilities toward dysregulation (Shore 2003). At the same time there are often few reliable protective factors such as strong and secure attachments that can enhance family members' sense of emotional or physical safety.

Clinical Constructs

ESFT is a clinical model that examines the biological and developmental influences of family members as well as current and historical familial, cultural, and ecological influences. ESFT is based on the fundamental assumption that child, parental, and marital functioning are inextricably linked to their relational environment. Five interrelated constructs guide ESFT therapists in their understanding of clinical problems: family structure; family and individual emotional regulation; individual differences (e.g., historical, biological, cultural, developmental); affective proximity (i.e., emotional attachment between parent and child and between parents); and family development (Gehart 2010).

Family Structure

As would be expected of an SFT-based model, family structure is the first construct around which clinical interventions are organized. As Minuchin (1974) first noted, all families have a hierarchical structure with reciprocal and complementary functions found among family members. While there are some universal components of family structure, there are also idiosyncratic aspects that must be considered clinically. ESFT directs clinicians to focus on the way that family members accommodate to one another (i.e., role complementarity or reciprocity), the mutual expectations of family members around daily routines (e.g., meals, sleep, work, recreation, intimacy), how close or distant the family members are (i.e., proximity and distance), how families organize and regulate themselves (i.e., boundaries and parameters), and the power differentials among members and generations (i.e., hierarchy) (Lindblad-Goldberg et al. 1998).

Affective Proximity

As mentioned above, proximity, also construed as involvement (the balance between dependency and autonomy), is an aspect of the family structure. However, of late ESFT clinicians have expanded the construct of involvement to consider the feeling of security in families. Following the lead of Bowlby (1969, 1988) that security and emotional proximity are biologically based, the concept of emotional proximity has been introduced to account for the role attachment plays throughout the life course. Close and securely attached relationships are promulgated when family members feel they can count on each other during times of stress or perceived threat.

Family and Individual Emotional Regulation

In ESFT, there is a clear focus, in both case formulation and treatment implementation, on how family members regulate their emotional experiences, as well as make meaning of them. Further, "…emotion and its regulation form the core of internal and interpersonal processes shaping the organization of self" (Jones and Lindblad-Goldberg 2002, p. 9). Focusing on emotions and emotional regulation in a family context not only directs the therapist's attention to the here-and-now interactions, but also to factors that have contributed to the development of various family structures and the experiences of connection therein. The recognition of emotional regulation as essential to family life not only acknowledges the interpersonal experiences of family members, but the intrapsychic and subjective experience of emotion. Consequently, a response by both the individual and

family is often necessitated when family members strive to maintain a subjective experience of internal organization in an attempt to avoid feeling out-of-control or reactive. This process of maintaining emotional organization in the family is a powerful organizer in regards to emotional closeness and distance in families. For ESFT therapists, helping relationship systems remain organized, emotionally connected, and emotionally balanced is paramount (Jones and Lindblad-Goldberg 2002).

Individual Differences

Just as the intrapersonal aspects of emotional regulation are important, there are other intrapsychic experiences that also contribute to the ways that families interact. From the outset, SFT has focused on facilitating the development of family systems that best fit the individuals within the family by accounting for individual family member needs and promoting positive growth and development (Minuchin 1974). This process of assisting families develop the best fit is still focal in ESFT and requires that clinicians comprehend and appreciate the tension between the intrapersonal and interpersonal domains. The progenitors of SFT and other family therapy models, in reaction to the almost exclusive focus on intrapsychic experience at the time, understandably highlighted observable family transactions and rendered the internal experience to the periphery. In contemporary ESFT, the pendulum has swung back to center with a patent appreciation of both the interpersonal and intrapersonal. ESFT "[t]herapists are encouraged to investigate as much about who are the players as about how they dance together" (Jones and Lindblad-Goldberg 2002, p. 12).

Family Development

In addition to the intrapsychic, interpersonal, and family organization, viewing the family from a life-cycle perspective is also critical in delivering ESFT. Utilizing a family life-cycle perspective focuses the clinician's attention on both the extant normative and non-normative demands that families face, as well as those that have been encountered previously. The family life-cycle perspective allows ESFT clinicians to take a more macro viewpoint acknowledging that current challenges may have originated from outside of the family, as well as from within.

Clinical Application

The development and refinement of the ESFT model from the earlier SFT model has resulted in a clearly articulated framework and training protocol for organizations and clinicians who wish to implement it. The theoretical and practical framework for the ESFT Model is described by Lindblad-Goldberg et al. (1998) in *Creating Competence from Chaos: A Comprehensive Guide to Home-Based Services*. The current ESFT model has four overarching goals that direct the work of clinicians:

- To resolve presenting problems and to eliminate negative interaction cycles;
- To shift the developmental trajectories of children, such that they are moving toward greater capacity for self-regulation and social-emotional competence;
- To enable a family to organize and emotionally connect in such a way that they become more growth-promoting in their interactions with one another; and

- To enable relevant community systems to organize in such a way that a family's efforts toward creating a growth-promoting context is nurtured (Jones and Lindblad-Goldberg 2006)

Stages of ESFT

There are four overlapping treatment stages within the ESFT model. However, it should be noted that these stages are not linear or discreet. As with other SFT-based intervention models, the first part of treatment is creating both the foundation for treatment (joining and engagement) and a meaningful focus by targeting focal areas for change to occur during the treatment process (assessment). The next stage involves an intensive collaborative effort aimed at specific change experiences by family members. The last stage promotes a deepening of families' understanding of how emotions and behaviors inhibit or promote change thereby engaging in problem-solving methods and other interventions that maintain changes and increase the family's ability to deal effectively with ongoing or future challenges. A brief description of the stages follow, but additional information on the stages of treatment and interventions can be found in a review of contemporary SFT (Jones and Lindblad-Goldberg 2002).

Stage One: Constructing a Therapeutic System

The first stage of ESFT involves both identifying those people and extra-familial systems that need to become part of the therapeutic system and inviting them to participate in the treatment process. Further, beginning the process of building a therapeutic alliance with each member of the therapeutic system (i.e., family members and other parties of interest) is important. The clinician partners with each family member to develop collaborative alliances with the goal of clarifying concerns and treatment expectations, fostering a shared understanding of assessment issues, and ultimately co-creating a treatment plan.

Stage Two: Establishing a Meaningful Therapeutic Focus

The second stage of the treatment process emphasizes the importance of the therapist's eliciting detailed descriptions of a child's presenting symptoms and its impact on functioning across major social contexts, such as family, school, peer group, and community. In addition to identification of the presenting problem(s), resources, family strengths and vulnerabilities, and supports are also indentified and integrated into boarder family themes that resonate with the treatment system.

While generally considered a distinct process, in ESFT, and SFT in general, there is considerable overlap between assessment and intervention (Lindblad-Goldberg et al. 2011; Lee 2011). In part the assessment process provided by the members of the therapeutic system teaches the clinician about the challenges they face and how the family operates. Clinicians are trained to use an inductive approach to treatment that focuses on data gathering, hypothesizing, intervention, and assessment of the family response (which becomes data gathering for the therapist) with the sequence repeating itself throughout the treatment process (Aponte and Van Deusen 1991).

The ESFT approach is predicated on clinicians understanding not only how strengths and difficulties among the IP and family members are exhibited, but also the bio/developmental/

systemic context wherein they become manifest. Ecomaps, critical life events time-lines, genograms, structural maps, and core negative interaction patterns are part and parcel of the assessment process. Additionally, during the assessment process the goal is for clinicians to:

1. strengthen the therapeutic alliance and sense of partnership with the family.
2. identify sources of motivation for change within the family;
3. contextualize the presenting problem(s) by providing a developmental, relational, contextual, trauma-informed reframe of the problem;
4. develop a clearly articulated circular hypothesis regarding the core negative interactional pattern maintaining the problem; and
5. propose then seek agreement to problem solving loops around a presenting complaint/ symptoms resulting in a treatment plan (Lindblad-Goldberg 2011).

During the biopsychosocial assessment, clinicians focus on developmental domains (i.e., cognitive, emotional, social, and physical); familial relational patterns both within the family (i.e., family structure) and between the family and the community; parenting supports, capacities, and skills; problem-solving; communication; understanding of children's individual differences; management of parental emotional and developmental challenges; and environmental responsiveness to the social emotional needs of their children (Lindblad-Goldberg et al. 2004).

It is important to note that in ESFT the therapeutic alliance with each individual family member and the family is fundamental to all change efforts. The therapeutic alliance is dependent on the degree that (1) there is a perceived bond between the family and the therapist; (2) there is agreement on the goals and tasks of the therapy between the family and the therapist; (3) there is a commitment to these goals and tasks; and (4) the family views themselves as contributing partners with the clinician (Bordin 1979). The therapeutic relationship is viewed as an action-oriented, non-hierarchical relationship based on mutual respect, collaboration, and partnership (Lindblad-Goldberg 2011).

Specifically, the developers of ESFT have promulgated four major principles designed to improve the chance of developing and maintaining a robust therapeutic alliance (Lindblad-Goldberg and Jones 2005). First, "presuming the positive," which is the basis of all effective reframes and assists families in demonstrating caring when it may be difficult, is crucial in developing the therapeutic alliance. The second principle focuses on creating a collaborative partnership with the family. The third principle calls attention to the accommodation to family members' communication and learning styles (Minuchin 1974). Finally, ESFT clinicians focus on building upon the individual and family strengths brought to the therapeutic process. These principles expound upon the concept of "joining" elucidated by Minuchin and his colleagues (Minuchin and Fishman 1981), which focuses on the attitudes and actions of therapists that indicate they understand, like, and accept the family as they are, thereby allowing the family to invite the clinician into their inner circle (Lindblad-Goldberg 2011).

Stage Three: Creating Key Growth-Promoting Experiences

The major focus of the third stage is to create interactional experiences to promote growth or change rather than a repetition of recurrent maladaptive patterns. The focus during this stage of treatment is to ameliorate the core negative interactional patterns manifest in families dealing with SED. These foci include: (1) strengthen parental executive skills; (2) promote co-caregiver alliances; (3) increase tolerance for frustration (self-regulation); and (4) create age expected parent–child connection/attachment. Here many of the

interventions associated with SFT are used, such as boundary making, increasing intensity, enactments, unbalancing, reframing, punctuation, etc. (Haley 1987; Minuchin and Fishman 1981; Nichols and Fellenberg 2000). Additionally, the clinician must use emotional challenge and emotional support to encourage new interpersonal interaction patterns.

The treatment process includes engaging family members whose interactions maintain the problem as well as those who are impacted by it. Additionally, those people who have the potential to support the therapeutic system and can assist in the development of new relationship or interaction patterns are actively engaged in the treatment process (Jones and Lindblad-Goldberg 2002). Specific goals are developed collaboratively with the members of the therapeutic system upon co-creation of the problems to be resolved. While these treatment goals are family specific, generally speaking they fall into one of the following broadly defined foci: (1) resolution of the presenting problem and elimination of the negative familial interaction cycles; (2) a shifting of the developmental trajectories of children, such that they are moving toward greater capacity for self-regulation and social-emotional competence; (3) enabling families to organize and emotionally connect in such a way that they become more growth promoting in their interactions with one another; and (4) enabling relevant community systems to organize in such a way that a family's efforts toward creating a growth-promoting context are supported (Lindblad-Goldberg and Jones 2005).

Stage Four: Solidifying Change and Termination

In the final stage of ESFT treatment, the goal is to help families integrate different themes generated in therapy as well as assist families in developing a clear conceptual understanding of how their behaviors produce their desired outcomes and how they can continue to do so. Here the responsibility for evoking change shifts from the clinician to the family members and the focus is on how families will deal with the problems, both ones dealt with in therapy and new ones that emerge. As with other SFT-based interventions, the changes created during the therapeutic process must generalize outside the therapy context.

Effectiveness of ESFT

The effectiveness of ESFT was formally assessed per the request of the Children's Bureau of the Office of Mental Health and Substance Abuse Services in the State of Pennsylvania as part of a statewide initiative to implement family-based mental health services. This ambitious multi-year evaluation focused on outcomes in a variety of contexts with assorted outcome measures and program evaluation projects and continues in various iterations to date. Most of these evaluation projects were never published in academic journals, but instead were submitted as outcome reports to the State of Pennsylvania (e.g., Dore 1991, 1996). The most significant of these program evaluations occurred between 1988 and 1995 as part of a state-wide evaluation initiative (Lindblad-Goldberg et al. 2004). During that period, over 4,000 families were served and data were collected and analyzed on almost half of the participating families and children from 39 different sites ($N = 1{,}968$).

The demographic data for the participants of the program evaluation can be found in Table 1. The majority of the families that participated in the evaluation identified as Caucasian, were single-parent headed households, and most of the parents had a high school education with a mean income of $21,000. The identified patients were more likely to be male (54 %), between the ages of 11 and 12 years, the eldest child, and with

Table 1 Family demographics

N = 1,968 Families from 39 FBMHS programs, 1988–1995
Racial composition
88 % Caucasian
5 % African-American
3 % Hispanic
1 % Asian
<1 % Native American
2 % Racially mixed
Family structure
20.5 % Two biological parents
26 % Include one non-biological parent
22 % Remarried parents (17 % stepfathers and 5 % stepmothers)
4 % Mothers with a live-in male partner
50 % Single parent households (23 % mother-only; 13 % father-only)
Educational levels
High school diplomas (68 % mothers; 69 % fathers)
Reported income levels
Average income: $21,000
Family functioning (measured by FAD)
Dysfunction in: problem solving, role allocation, behavior control, general functioning, communication, affective involvement, and affective responsiveness
Profile of identified patient
54 % male; 46 % female
Average age: 12 years
Most likely to be the oldest child in the family
Identified patient DSM diagnoses
50 % Depressive Disorders and Bipolar Disorders, Anxiety Disorders, Psychotic Disorders, Pervasive Developmental Disorders, Eating Disorders, Aspergers, Tourette's, Communication and Learning Disorders;
50 % Attention Deficit Disorder, especially Attention Deficit-Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorders

identified problems evenly split between "psychiatric problems" (e.g., Depressive and Bipolar Disorders, Anxiety Disorders, Psychotic Disorders, Pervasive Developmental Disorders, Eating Disorders, Asperger's, Tourette's, Communication and Learning Disorders) and "conduct problems" (e.g., Attention Deficit Disorder, especially Attention Deficit-Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorders). The problems assessed by the Family Assessment Device (FAD; Epstein et al. 1983) at intake were: problem solving, role allocation, behavior control, general functioning, communication, affective involvement, and affective responsiveness (Lindblad-Goldberg et al. 2004).

There were three primary outcome goals of interest for the State of Pennsylvania in regard to use of ESFT (Department of Public Welfare 1993): (1) a reduction in the incidence of psychiatric hospitalizations and other out-of-home placements for children and youth; (2) an enhancement of the families' ability to cope with a child or adolescent

with SED; and (3) enhancement of the psychosocial functioning of all family members, including the child with SED. Consequently, when treatment ended, follow-up data were collected at three, six, and twelve months on outcome variables such as psychiatric hospitalization and emergency room use for mental health crises. Outcome data were also collected on the status of problems addressed during treatment, post-treatment placement experiences, and current family involvement with other community service systems.

The analyses of the pre- and post-treatment data strongly support the effectiveness of the ESFT model. The most dramatic change was the reduction of out-of-home placements for both children and other family members. Prior to enrollment in the program 80 % of IPs experienced a psychiatric hospitalization. After the ESFT intervention the rate was reduced to 28 % for any family member, 20 % for the IPs, and only 13 % of families utilized emergency room care. The most common reasons for psychiatric hospitalization were unmanageable behavior (49 %) and depression/suicidality (28 %). Psychotic episodes (4 %), medication adjustment (5 %), and evaluation (11 %) were also cited as reasons for inpatient treatment. The length of stay for half of the participants was less than 1 month. Only 8 % of the IPs were placed in foster care 1 year post-treatment. In addition to the prevention of out-of-home placements, 77 % of the families reported that the problems they identified at the beginning of treatment were at least partially resolved and 95 % of participants said they would recommend ESFT to a friend with a similar problem (Lindblad-Goldberg et al. 2004).

The problems most commonly cited by families when they entered treatment were: (1) inadequate parenting skills, (2) acting out behavior of children, (3) school-related problems, (4) problems in family communication, (5) lack of responsible behavior in the child, (6) lack of respect for authority in the child, (7) weaknesses in the parent subsystem, (8) difficulties in the parent/child relationship, and (9) aggressive behavior in the child. The vast majority of families (82 %) were also satisfied with the school placement for their child with 42 % in regular classrooms.

The program evaluations also assessed the amount of time that families stayed in the program and the child's score on the Global Assessment Scale (GAS; Endicott et al. 1976). Almost two-thirds of the families remained in treatment between four and nine months and over three-quarters (78 %) completed treatment as planned. Again, the majority of families reported that the problem was completely resolved (26 %) or partly resolved (49 %) at the end of treatment. Only 7 % reported that the problem got worse. The child's GAS score at admission to the program was 48.7 ($SD = 10.8$) and improved to 59.6 ($SD = 14.2$). A *t test* on the means indicated that the differences were statistically significant ($t = 19.3460$; $p = .0001$).

These data indicate statistically significant positive pre-post changes in the identified patient's psychosocial functioning and in all family members' self-reports on all dimensions of family functioning. The one exception was that the identified patients did not report positive changes in all areas of family functioning (Dore 1996).

Implications

The practice of ESFT reflects the changing trends in the behavioral health field. For example, most managed care organizations have a linear perspective and require clinicians to create an individually-oriented treatment plan for the identified patient. These linear treatment plans must specify goals and objectives that are observable, measurable, and linked directly to changes in the child's current functioning. To meet the needs of

systemically-oriented ESFT clinicians, "ESFT Family Relational" treatment plans have been implemented to meet both the MCO's and the ESFT clinician's needs. Another behavioral health trend initiated both by consumers and funders of mental health services emphasizes that services to high risk families be delivered in the "least restrictive" setting such as the child's home and community rather than in an inpatient service or residential treatment facility. The recognition of the benefits of in-home and community-delivered services resulted in the State of Pennsylvania's decision to create a new statewide in-home/community service (i.e., Family-Based Mental Health Services using the ESFT model for families having high risk children or adolescents with SED; Lindblad-Goldberg et al. 1998). ESFT is delivered through three key program components, specifically individual and family therapeutic interventions, case management, and emergency crisis intervention. The ESFT model is team-delivered with each team serving a maximum of eight families for up to 32 weeks; this time period can be lengthened if needed. Usually between 2 and 10 h of direct service is given each week, although the crisis service operates 24 h a day, 7 days a week (Lindblad-Goldberg et al. 1998). Extensive training and supervision is provided to ensure fidelity to the model. Both the supervisors and staff receive 306 h of training over a 3-year period followed by 5 days of annual booster sessions for experienced staff and supervisors.

Conclusions

ESFT is both a unique model and one that shares a long history with the models predicated on the work of the structural and strategic family therapy pioneers. Hyde, Falls, Morris, and Schoenwald (2003) define evidenced-based practice as "…those clinical and administrative practices that have been proven to consistently produce specific, intended results" (p. 15). Further, they stress not only the importance of clinical trials, but application in real world settings as well (Hyde et al. 2003). Given the extensive utilization of ESFT, consistent clinical results, and the rigorous program evaluations, ESFT clearly fits that definition. ESFT has been effectively practiced in the State of Pennsylvania concurrently for the past 24 years with improved quality of life for families and an efficient utilization of resources from the often underfunded child mental health system.

As the available funds for the delivery of behavioral health services continue to dwindle, the competition for beneficial, cost-effective interventions for children and families will increase. Many of the extant models (e.g., BBFM, BSFT, FFT, MDFT, MST) used by agencies, and in some cases municipalities, moved quickly from theoretical development to the clinical labs in psychiatric departments where their efficacy was careful studied and the models explicated in clinical manuals. These evidence-based models have become the focus of a number of organizations and government entities interested in promulgating models with a strong empirical base (e.g., APA Division 12, Cochrane Collaboration [The Cochrane Collaboration, 2004] University of Colorado's Blueprints for Violence Prevention, National Advisory Mental Health Council, 2001; National Registry of Evidence-Based Programs and Practices [SAMSHA Model Programs, 2006]). In fact it has been suggested that the there is some vested interest in promoting these models because government funding was used to establish their efficacy (Littell 2005; Northey and Hodgson 2008). However, these models that have been developed and refined in the halls of academia have not fared as well when implemented in "real world settings" where staff turnover, varied clinical competence, diverse presenting problems, and stringent productivity expectations are the norm (Hansen et al. 2002; Northey 2009). Models like ESFT that

have emerged in the "real world" offer another model for developing, implementing, and disseminating EBPs.

ESFT might represent what some are calling "Practice-Based Evidence" (Duncan and Miller 2006), that is models developed and refined in the field. While these models often lack the rigorous empirical evaluation associated with many empirically supported treatments (ESTs), they more than make up for in clinical effectiveness and utility. That said, ESFT is primed to be assessed empirically with more rigorous methodologies. In fact, an adherence scale for ESFT has been developed and is being piloted for use in planned program evaluations and outcome studies.

References

Aponte, H., & Van Deusen, J. (1991). Structural family therapy. In A. S. Gutman & D. P. Kniskern (Eds.), *Handbook of family therapy* (pp. 310–360). New York: Brunner/Mazel.

Bateson, G. (1979). *Mind and nature*. New York: E.P. Dutton.

Becvar, D. S., & Becvar, R. J. (1982). *Systems theory and family therapy: A primer*. Lanham, MD: University Press of America.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research, and practice, 16*, 252–260.

Bowlby, J. (1969). *Attachment and loss: Vol. 1, attachment* (2nd ed.). New York: Basic Books.

Bowlby, J. (1988). *A secure base*. New York: Basic Books.

Byng-Hall, J. (1991). The application of attachment theory to understanding and treatment in family therapy. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 199–215). London: Tavistock Publications.

Colapinto, J. (1991). Structural family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy* (Vol. 2, pp. 417–443). New York: Brunner/Mazel.

Department of Public Welfare. (1993). Family based mental health services for children and adolescents (55PA. Code Ch. 5260). *Pennsylvania Bulletin, 23*(18), 2127–2136.

Diamond, G. S., Reis, B. F., Diamond, G. M., Siqueland, L., & Isaacs, L. (2002). Attachment-based family therapy for depressed adolescents: A treatment development study. *Journal of the Academy of Child and Adolescent Psychiatry, 41*, 1190–1196.

Dore, M. (1991). Effectiveness of state-wide implementation of a family-based approach to children's mental health services. In A. Algarin & R. Friedman (Eds.), *A system of care for children's mental health: Expanding the research base* (pp. 31–37). Tampa, FL: Research and Training Center for Children's Mental Health, Florida Mental Health Institute.

Dore, M. (1996). *Annual research report on family-based services*. Harrisburg, PA: Bureau of Children's Services, Pennsylvania Office of Mental Health.

Duncan, B. L., & Miller, S. D. (2006). Treatment manuals do not improve outcomes. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 140–148). Washington, DC: APA.

Elizur, J., & Minuchin, S. (1989). *Institutionalizing madness: Families, therapy, and society*. New York: Basic Books.

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The Global Assessment Scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry, 33*, 766–771.

Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy, 9*, 171–180.

Fishman, H. C. (1993). *Intensive structural family therapy: Treating families in their social context*. New York: Basic Books.

Gehart, D. (2010). *Mastering competencies in family therapy: A practical approach to theory and clinical case documentation*. Pacific Grove: Brooks/Cole.

Haley, J. (1987). *Problem-solving therapy*. San Francisco: Jossey-Bass.

Hansen, M., Litzelman, A., & Salter, B. (2002). Serious emotional disturbance: Working with families (Ch. 20). In D. T. Marsh & M. A. Fristad (Eds.), *Handbook of serious emotional disturbance in children and adolescents* (pp. 375–391). New York: Wiley.

Henggeler, S. W., Schoenwald, S. K., Borduin, C. M., Rowland, M. D., & Cunningham, P. B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford Press.

Hyde, P. S., Falls, K., Morris, J. A., & Schoenwald, S. K. (2003). *Turning knowledge into practice: A manual for behavioral health administrators and practitioners about understanding and implementing evidenced-based practices*. Albuquerque, NM: The American College of Mental Health Administration.

Jackson, D. D. (1957). The question of family homeostasis. *The Psychiatric Quarterly Supplement, 31*, 79–90.

Johnson, S. M. (1996). *The practice of emotionally focused marital therapy: Creating connection*. New York: Brunner/Mazel.

Lindblad-Goldberg M., & Jones, C. W. (2005). Contemporary structural family therapy: The basics. *Family Therapy Magazine, September/October*. Alexandria, VA: American Association for Marriage and Family Therapy.

Jones, C. W., & Lindblad-Goldberg, M. (2002). Ecosystemic structural family therapy: Elaborations of theory and practice. In F. Kaslow (Series Ed.) & R. Massey and S. Massey (Vol. Eds.), *Comprehensive handbook of psychotherapy: Vol. III. Interpersonal, humanistic and existential models* (pp. 3–33). New York: Wiley.

Jones, C. W., & Lindblad-Goldberg, M. (2006). *An ecosystemic structural family therapy approach to home-based intervention: A treatment manual*. Philadelphia, PA: The Philadelphia Child & Family Therapy Training Center.

Lee, Y. T. (2011). Structural family therapy. In L. Metcalf (Ed.), *Marriage and family therapy: A practice orientated approach* (pp. 229–254). New York: Springer.

Liddle, H. A. (2000). *Multidimensional family therapy treatment manual for Cannabis Youth Treatment Multi-site Collaborative Project*. Rockville, MD: Center for Substance Abuse Treatment.

Lindblad-Goldberg, M. (1986). Elective mutism in families with young children. In J. Hansen (Series Ed.) and Combrinck-Graham (Ed.) *Treating young children in family therapy* (pp. 38–50). Rockville, MD: Aspen.

Lindblad-Goldberg, M. (2006). Successful African-American single-parent families. In L. Combrinck-Graham (Ed.), *Children and families* (2nd ed.). New York: Guilford Publications.

Lindblad-Goldberg, M. (2011). *Ecosystemic structural family therapy training manual*. Philadelphia, PA: Philadelphia Child and Family Therapy Training Center.

Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competence from chaos: A comprehensive guide to home-based services*. New York: Norton.

Lindblad-Goldberg, M., Igle, E., & Simms, S. (2011). Ecosystemic structural family therapy with couples. In D. Carson & M. Casado-Kehoe (Eds.), *Case studies in couple's therapy: Theory based approaches* (pp. 121–131). New York: Routledge.

Lindblad-Goldberg, M., Jones, C. W., & Dore, M. (2004). *Effective family-based mental health services for youth with serious emotional disturbance in Pennsylvania: The ecosystemic structural family therapy model*. Philadelphia, PA: Philadelphia Child and Family Therapy Training Center.

Littell, J. H. (2005). Lessons from a systematic review of effects of Multisystemic Therapy. *Children and Youth Services Review, 27*, 445–463.

Lourie, I. S. (2000, September). As the twig bent. *Readings: A Journal of Reviews and Commentary in Mental Health, 15*, 18–22.

Marvin, R. S., & Stewart, R. B. (1990). A family systems framework for the study of attachment. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years: Research and intervention* (pp. 51–86). Chicago: University of Chicago Press.

Minuchin, S. (1974). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Minuchin, S., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge, MA: Harvard University Press.

Minuchin, S., & Nichols, M. (1993). *Family healing*. New York: Free Press.

Minuchin, S., Rosman, B., & Baker, L. (1978). *Psychosomatic families*. Cambridge, MA: Harvard University Press.

Nichols, M. P., & Fellenberg, S. (2000). The effective use of enactments in family therapy: A discovery-oriented process study. *Journal of Marital and Family Therapy, 26*, 143–152.

Nichols, M., & Schwartz, R. (1998). *Family therapy: Concepts and methods*. Needham, Heights, MA: Allyn & Bacon.

Northey, W. F, Jr. (2009). Effectiveness research: A view from The U.S.A. *Journal of Family Therapy, 31*, 75–84.

Northey, W. F, Jr, & Hodgson, J. (2008). Empirically supported therapies: Training opportunities and evidence of success. *Journal of Family Psychotherapy, 19*, 50–84.

Shore, A. N. (2003). *Affect regulation and the origin of the self: The neurobiology of emotional development*. Hillsdale, NJ: Erlbaum.

Szapocznik, J., & William, R. A. (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*, 117–134.

Van der Kolk, B. A. (2005). Developmental trauma disorder: Towards a rationale diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*, 401–408.

Watzlawick, P., Beavin, J. H., & Jackson, D. D. (1967). Some tentative axioms of communication. In *Pragmatics of human communication: A study of interactional patterns, pathologies, and paradoxes* (pp. 48–71). New York, NY: W. W. Norton & Company.

Wood, B. L., Klebba, K. B., & Miller, B. D. (2000). Evolving the biobehavioral family model: The fit of attachment. *Family Process, 39*, 319–344.

Woods, L. J. (1988, May–June). Home-based family therapy. *Social Work*, pp. 211–214.