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Stage 2 Outpatient Adolescent Recovery (SOAR) Program Family Therapy Manual

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School of Behavioral Health
in conjunction with the
Department of Psychology

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by

Sarah Yelim Nam An

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A Project submitted in partial satisfaction of
the requirements for the degree
Doctor of Psychology

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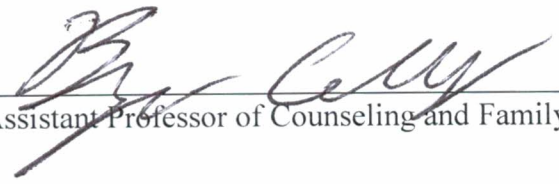
Each person whose signature appears below certifies that this project in his/her opinion is adequate, in scope and quality, as a project for the degree Doctor of Psychology.

, Chairperson

Kendal C. Boyd, Associate Professor of Psychology



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To my husband, without whom I would not have been able to accomplish so much with the kind of peace and confidence I was able to, words cannot express how thankful I am for your presence in my life.

CONTENT

ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
DBT-A	Dialectical Behavioral Therapy for Adolescents
DBT	Dialectical Behavioral Therapy
SOAR	Stage 2 Outpatient Adolescent Recovery
SFT	Structural Family Therapy
CBT	Cognitive Behavioral Therapy
FFT	Functional Family Therapy
MFT	Multisystemic Family Therapy
MDFT	Multidimensional Family Therapy
SCCAP	Society of Clinical Child and Adolescent Psychology
PH	Parental hierarchy

ABSTRACT OF THE DOCTORAL PROJECT

Stage 2 Outpatient Adolescent Recovery (SOAR) Program Family Therapy Manual
by

Sarah Yelim Nam An

Doctor of Psychology, Graduate Program in Psychology
Loma Linda University, September 2020
Dr. Kendal C. Boyd, Chairperson

Rising suicide rates among adolescents is a serious public health concern. The frequency of self-injurious thoughts and behaviors drastically increases in the transition from childhood to adolescence (Nock et al., 2008; Nock et al., 2013). Suicide was the third highest cause of death between 1999-2006 for adolescents between the ages of 12 and 19, following unintentional deaths and homicide (Miniño, 2010). Despite the growing problem of adolescent suicide, treatments that meet Level One criteria, the highest level of research support for therapy as defined by the American Psychological Association (APA, 2006), are lacking. Dialectical Behavioral Therapy for Adolescents (DBT-A), a treatment adapted from Dialectical Behavioral Therapy (DBT) for adults who engage in suicidal and self-harm behaviors (Miller et al., 2007), has been examined with studies finding promising results with reducing self-injurious thoughts and behavior (Freeman et al., 2016; Rathus & Miller, 2002). There is also a need for treatments addressing self-injurious thoughts and behaviors that are designed to work with the unique needs and systemic factors of adolescents. Studies have shown that effective treatment of self-injurious thoughts and behaviors include varying elements of family involvement with DBT-A. The aim of this treatment manual is to combine evidence-supported family integration to DBT-A treatment in order to more comprehensively

address the needs of self-injurious adolescents and improve outcomes. Specifically, this treatment manual is designed to establish a systemic and robust family therapy component to an existing adolescent recovery program, Stage 2 Outpatient Adolescent Recovery (SOAR), with the family therapy sessions conducted using Structural Family Therapy (SFT) interventions.

CHAPTER ONE

CLINCAL IMPORTANCE OF PROBLEM

Clinical Importance

Rising suicide rates among adolescents is a serious public health concern. The Centers for Disease Control and Prevention (CDC) defines suicidal, self-directed violence or suicidal self-injurious behavior as a deliberate, self-directed behavior that results in injury or has the potential for injury (Crosby, Ortega, & Melanson, 2011). The frequency of self-injurious thoughts and behaviors drastically increases in the transition from childhood to adolescence (Nock et al., 2008; Nock et al., 2013). In the period between 1999-2006, suicide was the third highest cause of death for adolescents between the ages of 12 and 19, following unintentional deaths and homicide (Miniño, 2010). The most recent data from the CDC (2010) reports approximately 4,600 adolescent deaths due to suicide. Further, according to the 2017 Youth Risk Behavior Surveillance by Kann et al. (2018), 17.2% of high school students have seriously considered attempting suicide, an increase from 14.5% in 2007. Data also showed that 13.6% of high school students reported having made a suicide plan with 7.4% having attempted suicide and 2.4% having been injured in a suicide attempt (Kann et al., 2018). The upward trend of self-injurious behavior in adolescents suggests the importance of establishing effective, evidence-based treatments to prevent self-harm behaviors in this high-risk population.

Despite the growing problem of adolescent suicide, treatments that meet Level One criteria, the highest level of research support for therapy as defined by the American Psychological Association (APA, 2006), are lacking. There are some ‘probably

efficacious therapies' or Level Two therapies[1], which are therapies that have strong research support but "may not have been tested by different or independent teams, like Level One therapies" (APA, 2006). Another therapy that addresses adolescent self-injurious thoughts and behaviors is Dialectical Behavioral Therapy for Adolescents (DBT-A), which is a treatment adapted from Dialectical Behavioral Therapy (DBT) for adults who engage in suicidal and self-harm behaviors (Miller et al., 2007). Studies examining the efficacy of DBT-A has found promising results with reducing self-injurious thoughts and behavior (Freeman et al., 2016; Rathus & Miller, 2002).

With the absence of Level One therapies and need for more rigorous DBT-A studies, it is important to invest in the development of a comprehensive treatment for adolescents engaging in self-injurious behavior. There is a need for treatments addressing self-injurious thoughts and behaviors that are designed to work with the unique needs and systemic factors of adolescents. Studies have shown that familial problems and relational difficulties are the most common reasons for adolescents engaging in self-injurious behavior, which highlights the importance of adolescent treatment including interventions aimed at increasing relational functioning of the family (Glenn, Franklin, & Nock, 2015). Many Level Two therapies that show evidence of effective treatment of self-injurious thoughts and behaviors include varying elements of family involvement[1,2]. It is the aim of this treatment manual to combine the evidence-supported family integration not limited to skills training to DBT-A treatment to more comprehensively address the needs of self-injurious adolescents and improve DBT-A treatment outcomes. Specifically, this treatment manual is designed to establish a systemic and robust family therapy component to an existing adolescent recovery program, Stage 2 Outpatient Adolescent

Recovery (SOAR), with the family therapy sessions conducted using Structural Family Therapy (SFT) interventions.

CHAPTER TWO

THEORY, LITERATURE REVIEW, AND AIMS OF MANUAL

Literature Review

Dialectical Behavioral Therapy for Adolescents

Dialectical behavioral therapy (DBT), derived from CBT, operates on a foundation of understanding that individuals have biological vulnerabilities and invalidating environments that led to the dysregulation and poor coping skills. DBT incorporates distress tolerance, emotion regulation, and interpersonal effectiveness, to reduce therapy interfering behavior prior to processing trauma. Melhum et al (2016) found that DBT for adolescents was effective in decreasing short-term and long-term self-harming behavior, suicidal ideation, and depression. Research has demonstrated that Dialectical Behavior Therapy for Adolescents (DBT-A), adapted from Marsha Linehan's Dialectical Behavior Therapy (DBT) for the treatment of adolescents exhibiting self-harming behaviors and suicidal ideation, results in significant reductions in suicidal behavior (Fleischhaker et al., 2011; James et al., 2008; James et al., 2011; James et al., 2014; Katz et al., 2004; Mehlum et al., 2014; Perepletchikova et al., 2011; Rathus & Miller, 2002; Tørmoen et al., 2014; Woodberry & Popenoe, 2008). Studies that conducted follow-up assessments found that these reductions were maintained at four months, eight months, and one year post-treatment (Fleischhaker et al., 2011; James et al., 2008; Katz et al., 2004; Tørmoen et al., 2014).

Whereas some of these studies were conducted with treatment focused only on the

adolescent, others have shown positive results with the inclusion of the adolescent's family primarily through skills groups (Fleischhaker et al., 2011; James et al., 2014; Rathus & Miller, 2002; Tørmoen et al., 2014) with two studies including limited family therapy (Mehlum et al., 2014; Woodberry & Popenoe, 2008). Despite results indicating DBT-A efficacy, these studies establishing DBT-A as an evidence-based treatment has primarily been limited by the absence of repeated studies by independent teams working in different settings, no published randomized controlled trials, and no published studies finding DBT-A to be "superior to an active treatment control" (Glenn et al., 2015). Further, while DBT-A has shown positive results with adolescents engaging in self-injurious thoughts and behaviors, there are factors that can enhance positive outcomes. Another limitation of DBT-A research could possibly be the absence of family involvement in treatment beyond skills training. Studies have found significant improvement in adolescent and family functioning with the inclusion of family components in adolescent DBT treatment (Hoffman et al., 2007; Rajalin et al., 2009).

DBT is organized into four stages with distinct goals or target behaviors. The clear majority of DBT-A research has primarily been comprised of Stage 1 (Kimberly et al., 2016; Rathus & Miller, 2015). However, the limited focus of Stage 1 DBT targets being to "attain basic capacities that establish safety and behavioral control" (Rathus & Miller, 2015) may be a limitation of existing DBT-A research supporting DBT-A as a superior treatment for adolescent self-injurious thoughts and behaviors. Kimberly et al. (2016) suggested that many adolescents remain in clinical ranges in various areas of functioning post-Stage 1 DBT-A treatment, which indicates the need for continued treatment in the latter stages after achieving the targets of Stage 1. Success in attaining

Stage 1 targets prepares adolescents to engage in treatment focused on trauma processing, which helps to decrease traumatic stress and increase healthy emotional experiencing (Linehan, 1993). Continued treatment into Stage 2 could increase the potential for long-lasting effects of DBT-A treatment. Further, strengthening the family system at this stage of treatment would provide the adolescent a strong family support system to help maintain progress made through processing difficult experiences and emotions. With a supportive and validating support system found within the family, the adolescent would be able to more fully invest in and successfully achieve the targets of Stage 3, "increasing self-respect and achieving individual goals, addressing normal problems in living," and Stage 4, "finding joy, meaning, connection, and self-actualization" (Linehan, 1993).

The importance of family involvement in treatment has been supported by the inclusion of family components in most research supported treatments for adolescent self-harm behaviors including DBT. Linehan (1993) suggested parenting behaviors as a possible etiological factor of emotional dysregulation and self-harming behavior development and Millet et al. (2007) incorporated the family in treatment when adapting DBT for adolescents. Family inclusion in treatment is also congruent with developmental considerations since parenting is a primary influencer of emotional skill development including emotion regulation (Calkins & Hill, 2007), Increased family involvement in Stage 2 treatment in particular is a necessary component considering that Stage 2 targets are focused on processing intense emotional experiences and reducing traumatic stress. More intensive family involvement such as family therapy would provide an opportunity for increasing the capacity for emotion regulation. Although Stage 2 includes family components in the form of family skills training, making modifications through family

therapy can further foster a family environment of parental modeling and reinforcement of healthy behaviors, validation, and effective family communication and conflict resolution. Considering that parent-child conflict, decreased positive interactions, and the absence of effective communication are significant risk factors for suicidality (Eisenberg et al., 2008; Klaus, Mobilio, & King, 2009; Lewinsohn, Rohde, & Seely, 1994; Steinberg, 2001), family therapy provides an ideal setting to fully explore and address these issues. Moreover, family therapy creates an opportunity to address invalidation, which is considered to be a key factor in developing severe emotion dysregulation according to Linehan (1993). Working with the family through a family therapy component can help create a supportive and validating environment that encourages continued engagement in safety, healthy emotional experiencing, and decreased traumatic stress, which are the primary targets of Stage 2. Establishing a solid family support system helping to maintain the progress made through the first two stages in DBT-A treatment sets up the adolescent for success in Stage 3 and Stage 4 treatment towards discovering their own life worth living (Linehan, 1993).

SHIELD and SOAR

The SHIELD Program for Adolescent Self-Injury operated by the Behavioral Medicine Center at Loma Linda University is a Stage 1 outpatient program for adolescents utilizing intensive DBT-A (Ballinger et al., 2016). In efforts to continue meeting the needs of adolescents who graduate the SHIELD program, a second program was created. The 16-week Stage 2 Outpatient Adolescent Recovery (SOAR) program was developed to further address the emotional and behavioral difficulty and maintenance of

DBT skills for graduates of SHIELD (Ballinger et al., 2016). Current components of the SOAR program include adolescent individual therapy, group sessions for adolescents, and group sessions for parents. Analysis of SOAR data indicated that parents reported desiring increased parent involvement in adolescent treatment and that parent groups met their need for a support system of other parents and psychoeducation with DBT skills training complementary to what their adolescents experience in their own group sessions (Nam et al., 2018a). Further, SOAR data of parent-adolescent feedback on the program showed significant discrepancies between parents and adolescents regarding the utilization of skills learned and progress maintained post-treatment (Nam et al., 2018b). This data suggests a need for family integrative components to the SOAR program.

Family-Based Treatment

Evidence strongly supports the inclusion of families or parents in the treatment of adolescents engaging in self-injurious thoughts and behaviors. “Common elements across efficacious treatments included family skills training (e.g., family communication and problem solving), parent education and training (e.g., monitoring and contingency management), and individual skills training (e.g., emotion regulation and problem solving)” (Glenn et al., 2015). This is evident in the therapies categorized as ‘probably efficacious therapies’ and meeting Level Two criteria for evidence-based treatment (APA, 2006). Specifically, efficacious treatments generally targeted the relational or interpersonal functioning of the family with almost all treatments having included the adolescent’s family or parents in the process (Glenn et al., 2015).

Research on parent-adolescent agreement on adolescent suicidal thoughts and

behaviors has shown that parents reported significantly less suicidal thoughts and behaviors in comparison to adolescents (Klaus et al., 2009). As previously mentioned, data indicated that even in a family integrative treatment program as SOAR, there were significant discrepancies between parents and adolescents regarding the utilization of skills learned and progress maintained post-treatment (Nam et al., 2018b). Family sessions focused on improving communication, addressing systemic issues that act as barriers to decreased symptom maintenance, and practicing skill use integration to the family system could increase positive outcomes after SOAR graduation.

Family Systems Theory

The family systems perspective is "based on the general systems theory which emphasizes the organization and interactions of elements within systems" (von Bertalanffy 1968). As a term mostly associated with the work of Murray Bowen, family systems theory conceptualizes the family and problematic symptom assuming that "all important people in the family unit play a part in the way family members function in relation to each other and in the way the symptom finally erupts" (Bowen, 1974). Various different family therapies have their unique views on the role of the symptom in relation to the family system. In example, SFT views the symptom as a behavior that is being sustained by the complementary interactions of each family member (Minuchen et al, 2007). Therefore, identifying and targeting problematic interactions sustaining the symptom through the restructuring of the family structure is the focus of SFT treatment.

General and family systems theory suggest that the whole, or the family, is greater than the sum of its parts. The individual members of the family have an "ongoing and

mutual impact on one another," and that individual family members must always be understood through the context of the larger family system (Cox & Paley 1997). Family therapy can "offer a safe environment where families can get the education, support, and training they need to improve their family dynamics and communication which will in turn help their loved ones feel secure enough to overcome self-injury (Halstead, Pavkov, Hecker, & Seliner, 2014).

Structural Family Therapy

Salvador Minuchin is chiefly attributed to the development of SFT, which is thought of as an archetypal family therapy approach (Gehart, 2018). The focus of SFT is on the family structure through which psychological symptoms and relational problems are addressed (Minuchin & Fishman, 1981). The family structure is built with boundaries, hierarchies, and subsystems, which are used to restructure the family, adjust boundaries and hierarchies to support family growth and problem resolution (Gehart, 2018). "Although no manual has been created to make [SFT] an empirically supported treatment, the components of structural therapy have been used in many empirically supported treatments, especially those targeting youth" (Gehart, 2010). Some of these evidenced-based treatments include Brief Strategic Family Therapy, Ecosystemic Structural Family Therapy, Functional Family Therapy (FFT), Multisystemic Family Therapy (MFT), and Multidimensional Family Therapy (MDFT) (Gehart, 2018; Henggeler & Sheidow, 2012; Radohl, 2011). Of these SFT-rooted treatments, FFT, MDFT, and MFT are considered Two Family-based Treatments by the Society of Clinical Child and Adolescent Psychology (SCCAP). Accordingly, discussion of literature

supporting the use of SFT for the family-based therapy component of the SOAR program will include literature on SFT as well as literature on therapies rooted in SFT as they utilize key elements of SFT.

Studies examining the efficacy of SFT in the treatment of adolescents experiencing distress endorsed the utility of addressing systemic issues through the tenets of SFT. In a study of 189 participants within the age range of 18-55 years old and with the average first incident of self-injury being 13 years old, Halstead et al. (2014) found that unhealthy family dynamics were positively correlated and associated with increases in self-injury behaviors. Specifically, healthy family dynamics were linked with decreased duration, frequency, periodicity, and severity of self-injurious behaviors. Lindahl, Breman, and Malik (2012) reported that examination of 270 couples with a child between the age range of 6-12 years old indicated that family boundary disturbances were correlated with emotional reactivity and child adjustment. The results suggest that interventions targeting positive youth adjustment should include boundary realignment, adjustment of communication patterns, and training in coping skills for emotional reactivity.

Therapies rooted in SFT such as MFT, MDFT, and FFT have also suggested that SFT interventions have significant effects in decreasing adolescent self-destructive behavior and emotional disturbances. Social ecology theory is the theoretical bases of MFT (Henggeler & Sheidow, 2012). Fundamental interventions utilized in MFT include realignments of boundaries and attention to maladaptive and repetitive family interactional patterns. A study evaluating the efficacy of MFT in decreasing suicide attempts among predominantly African American adolescents found that MFT was

effective in reducing suicide attempts one-year posttreatment (Huey et al., 2004). In a study of 113 youth presenting with psychiatric emergencies, MFT was found to be more effective in stabilizing youth in crisis compared to hospitalization (Schoenwald, Ward, Henggeler, & Rowland, 2000). Other studies found that MFT was effective in significantly decreasing behavioral problems and symptoms, increasing positive family and peer relations, decreasing serious emotional disturbances, and increasing functioning (Borduin, Schaeffer, & Heiblum, 2009; Stambough et al., 2007).

MDFT treatment uses a multisystemic orientation to target change in adolescents, parents, family environment, and other influential systems (Liddle, 2002; Rowe, 2012). Interventions rooted in SFT include the realignment of family hierarchy and use of enactments (Carr, 2016). The majority of research on the efficacy of MDFT is focused on its effects on the treatment of adolescent drug use. In addition to the significant reduction in drug use, studies show that adolescent treatment using MDST interventions also show improved functioning in various domains with gains maintained posttreatment (Liddle et al., 2009). Other studies have shown that MDFT is efficacious in decreasing behavioral and emotional problems (Liddle, 2015; Rowe, 2012).

FFT is a therapy based on a multisystemic viewpoint and utilizing core SFT interventions such as a focus on relational connectedness and hierarchy as well as realigning problematic relational patterns (Alexander & Parsons, 1982; Gehart, 2018). Most studies assessing the efficacy of FFT are also focused on adolescents engaging in risky and self-destructive behaviors such as substance use. However, findings indicate that FFT interventions significantly reduce risky behavior in adolescents (Waldron, Slesnick, Brody, Turner, & Peterson, 2001; Slesnick & Prestopnik, 2004; Slesnick &

Prestopnik, 2005).

Dialectical Behavior Therapy and Structural Family Therapy

Utilizing SFT and DBT-A through an integrated approach lends for an integrated and cohesive theory in approaching the patient through systemic and holistic lenses (Finney & Tadros, 2018). The use of both modalities cohesively address therapeutic change at the family and individual level. An example of this is how SFT explores the symptom through tracking interactions of the family, whereas DBT-A utilizes behavior chain analysis of problematic behaviors. Both of these strategies serve to aid in identifying problematic behaviors or interactions in order to implement therapeutic change. The foundational constructs of DBT-A and SFT work complementary with each other as shown in this manual.

Aim of Manual

There is a lack of comprehensive treatment programs for adolescents engaging in self-injury encompassing individual therapy needs and acknowledgment of systemic influences on recovery. The purpose of this manual is to design a systemic and comprehensive family-oriented component that compliments the existing SOAR program using SFT. The family therapy component will augment the SOAR program and increase its efficacy in maintaining decreased adolescent self-injurious behaviors over time. Family sessions will accomplish this by addressing systemic factors in the family that can impede or support the maintenance of progress achieved through the SOAR program. In addition, family sessions will serve as an opportunity to address incongruences between

adolescent and parent feedback of the SOAR program as indicated in the exploration of existing SOAR data. This opportunity will help in increasing family communication and collaboration skills. Further, through creating a space for adolescents and their families to discuss the progress they have made in their separate experiences in the program, adolescents and their families will be able to complete the SOAR program with an increased understanding of how to continue using skills developed in the program and how to support each other in the use of such skills.

CHAPTER THREE

METHOD

Target

This manual targets professionals who are treating adolescents engaging in self-injurious behavior through a treatment program that utilizes DBT-A and involves family training and groups. The target treatment population for this manual is adolescents who engage in self-harm behaviors and their families who have graduated from the SHIELD program and have met criteria to graduate from the SOAR program.

Criteria

Peer-reviewed academic resources on structural family therapy (SFT) and SFT-based therapies will be referenced to inform the formulation of SFT informed treatment, SFT training of clinicians, and structure of sessions. Further, treatments that are categorized as having the most evidence-supported treatment according to the Society of Clinical Child and Adolescent Psychology, Division 53 of the APA, will inform the design of this manual. SOAR research meetings will be utilized to make appropriate adjustments to the content and format of the treatment manual so it is complementary to the overall SOAR treatment program.

Manual Outline

The manual will be divided into two main sections. The first section will include informational content for clinicians in preparation of delivering SFT in SOAR family

sessions. Clinicians will be provided with an introduction of family systems theory and SFT. Core elements of SFT (boundaries, assessment of boundaries, parental hierarchy, and symptom roles), goals of SFT, and SFT interventions (enactments, challenging the family's worldview, and shaping competence) will be discussed through informational content and opportunity for practice through vignette examples.

The second section of the manual will outline each phase of treatment and session content by treatment phase. The first session of SOAR family therapy is the introduction phase, which aims to introduce the purpose and format of the family sessions. The therapist goals in this session include boundary assessment, identifying of the symptom role, goal setting, and addressing expectations. Other supportive activities will include setting clear boundaries, establishing the parental hierarchy, and checking-in on DBT skills use. Sessions two and three will be the working phase. In these sessions, the therapist will introduce and invite the family to practice enactments. The therapist will check-in on DBT skills use at every session and provide appropriate support as needed. The remaining sessions, up to a sixth session, can either be a continuation of the working phase or the termination phase depending on the clinician's assessment of the family's functioning. The termination phase will address any remaining minor issues and may include a ritual component commemorating the completion of the family sessions.

Treatment Implementation

The SHIELD Program for Adolescent Self-Injury operated by the Behavioral Medicine Center at Loma Linda University is a Stage 1 outpatient program for adolescents utilizing intensive DBT-A (Ballinger et al., 2016). The 16-week Stage 2

Outpatient Adolescent Recovery (SOAR) program was developed to further address the emotional and behavioral difficulty and maintenance of DBT skills for graduates of SHIELD (Ballinger et al., 2016). This treatment manual will be implemented as part of a revamped SOAR program that seeks to include a family therapy portion for adolescents in the SOAR program who have met criteria for graduation from the program.

Treatment Assessment

Tracking adolescent progress and maintenance of symptoms is an impotent component in order to ascertain treatment efficacy. The main factors that need to be tracked for the purposes of DBT-A treatment are adolescent suicidality and well-being. This includes measuring for levels of suicidal ideation, self-injurious thoughts and behaviors, and other distress factors such as symptoms of anxiety and depression. In assessing for the efficacy of this manual, it may also be beneficial to track the parent-child relationship. There are many instruments that previous studies have used to track adolescent functioning. The Suicidal Ideation Questionnaire, appropriate for adolescents in Grades 10-12 (Reynolds, 2013a), and the Suicidal Ideation Questionnaire-JR, appropriate for adolescents in Grades 7-9 (Reynolds, 2013b), are measures that have been used by many studies to track suicidal ideation and self-injurious thoughts. The Lifetime Parasuicide Count (Linehan, & Comtois, 1994) is another instrument frequently used in DBT research to measure present, future, and past self-injurious behavior. For measuring various behaviors, previous studies have used the Child Behavior Checklist and Youth Self Report (Achenbach & Rescorla, 2001). The Youth Outcome Questionnaire (Burlingame, 2005) has also been used by DBT-A studies to obtain a measurement of

treatment progress. DBT-A Diary Cards (Miller et al., 2007) have also been used to track suicidality, self-harm, various distressing emotions, skill use, and maladaptive behaviors. Regarding family functioning, the Parent-Child Relationship Inventory (Gerard, 1994) can provide insight on the parents' attitudes about parenting and their children.

CHAPTER FOUR

CLINICIAN TRAINING MANUAL

Introductory Content for Clinicians

Evidence strongly supports the inclusion of families or parents in the treatment of adolescents engaging in self-injurious thoughts and behaviors. Common factors shared among treatments shown to be efficacious “included family skills training (e.g., family communication and problem solving), parent education and training (e.g., monitoring and contingency management), and individual skills training (e.g., emotion regulation and problem solving)” (Glenn et al., 2014). This is evident in the therapies categorized as ‘probably efficacious therapies’ and meeting Level Two criteria for evidence-based treatment (APA, 2006). Specifically, efficacious treatments generally targeted the relational or interpersonal functioning of the family with almost all treatments having included the adolescent’s family or parents in the process (Glenn et al., 2014). Further, research on parent-adolescent agreement on adolescent suicidal thoughts and behaviors has shown that parents reported significantly less suicidal thoughts and behaviors in comparison to adolescents (Klaus, Mobilio, & King, 2009). Previous SOAR data indicated that there were significant discrepancies between parents and adolescents regarding the utilization of skills learned and progress maintained post-treatment (Nam et al., 2018). Family sessions focused on improving communication, addressing systemic issues that act as barriers to decreased symptom maintenance, and practicing skill use integration to the family system could increase positive outcomes after SOAR graduation.

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2018).

Core Components

Delivering SFT involves conducting boundary assessment, understanding the parental hierarchy, identifying the role of the symptom, and effective utilization of SFT interventions. The following discussion of SFT components was adapted from “Structural Family Therapies,” by D. R. Gehart, 2018, *Mastering Competencies in Family Therapy: A Practical Approach to Theories and Clinical Case Documentation* (3rd ed.), pp. 135-152. Copyright 2018 by Cengage Learning.; “Structural Family Therapy,” by J. Colapinto, 1991, *Handbook of Family Therapy* (Vol. 2), pp. 417-443. Copyright 1991 by Brunner/Mazel.; and *Family Therapy Techniques*, by S. Minuchin & H. C. Fishman, 1981. Copyright 1981 by Harvard University Press.

Boundaries

Minuchin describes boundaries as the family’s rules for relating to one another. There are three types of boundaries: clear, enmeshed and diffuse, or disengaged and rigid boundaries. Clear boundaries are “normal boundaries” where families are able to have close emotional contact with others while allowing for an individual sense of identity and differentiation. Diffuse or weak boundaries lead to relationship enmeshment, which favors strong family connection at the expense of individuality. In session, families with diffuse boundaries commonly display behaviors like speaking out of turn or speaking for others, mindreading or making assumptions, insistence of excessive protectiveness or overt concern, demanding of loyalty and disregard of individual needs, and feeling

threatened at any disagreement or expression of difference. Rigid boundaries give rise to relational disengagement and favor autonomy and independence at the expense of family connectedness. Typical behaviors displayed by families with rigid boundaries are deficient reactions to positive or negative situations, significant freedom to do as each individual family member chooses, little expressed or desired loyalty or commitment, utilization of parallel interactions instead of meaningful interactions or engagement.

Parental Hierarchy

In SFT, the family is considered a single system that is comprised of multiple subsystems. The most important systemic factor to assess for in the family is the parental subsystem. Specifically, the parental and couple subsystems should be clearly differentiated along with the parental and child subsystems maintaining clear boundaries. The parental hierarchy (PH) can be assessed as effective, insufficient, and excessive. An effective PH sets clear boundaries and limits while still allowing room for emotional connection with the child. An insufficient PH is unable to effectively manage the child's behavior, engages in a permissive parenting style, and often has enmeshed boundaries. Excessive PHs exhibit parenting styles that often impose rules that are too strict and unrealistic considering developmental norms and apply punishments that are too severe that they are ineffective. Families with an excessive PH usually have rigid boundaries and need to work on developing stronger emotional connections.

Identifying the Symptom Role

In order to address problematic family interactions, the role of the symptom and

the role of the family system is identified. The relationship between the symptom and the family system is targeted for change. There are three relational positions the family system takes, which are the ineffectual challenger, shaper, and beneficiary. As an ineffectual challenger to the symptom, the family is characterized as being passive and the symptomatic family member is unchallenged so as to maintain a problematic homeostasis. The symptom shaper family system shapes the symptomatic family member's experience and behaviors in a manner that results in problematic symptoms. When the family system is identified as the beneficiary of the symptom, the symptoms serves to regulate the family's homeostasis, often serving as a way to distract from other problematic factors.

Interventions

There are four main interventions in SFT, which are enactments, challenging the family's certainty and worldview, unbalancing, and expanding the family's truths and realities.

Enactments. An enactment is a clinician prompted re-enactment of a relevant conflict or interaction. Instead of merely talking about interactions, the family provides a sample with which the clinician can assess where and how to restructure the family and incite change in those areas. There are three phases to enactment: tracking and mapping, eliciting transactions, and redirecting alternative interactions. In tracking and mapping, the clinician observes the family's spontaneous interactions. By carefully tracking the content and process of the interactions, the clinician listens for the rules and assumptions

underlying the interactions. Based on these observations, the clinician ‘maps’ the boundaries and hierarchy of the family. Eliciting transactions involves inviting the family to enact interactions by directing the family to engage in an enactment or observing spontaneous enactments of existing patterns of interactions, often through arguments in session. Lastly, redirecting alternative transactions involves the clinician actively engaging in the enactment and facilitating change by redirecting behaviors that help to clarify boundaries and hierarchies. Boundary making is a specific type of enactment that addresses over- or under-involvement in order to promote change to rigid or diffuse boundaries. By directing specific members for enactment, the clinician can actively set boundaries by interrupting existing interaction patterns, giving family members the opportunity to experience underutilized abilities and skills.

Target family’s worldview. Targeting the family’s worldview is a way in which SFT clinicians can guide the family in the change process. One way is by challenging the family’s certainty and worldview involves targeting unproductive assumptions by questioning the family system’s operational assumptions, whether it is in overt speech or covert actions. By examining the utility of the assumptions, the family members are given the opportunity to assess whether the assumptions are resulting in the desired effect. Another way of targeting the family’s worldview is by expanding the family’s truths and realities.

Other re-aligning methods. Other methods of re-aligning the hierarchy and boundaries include intensity and crisis inductions as well as unbalancing. Intensity

inductions help to shift boundaries and hierarchies by creating changes in the family members' affect. Particularly in situations where the family have difficulty accepting alternative ways of thinking or interacting, the clinician attempts to elicit more intense emotions by utilizing their tone of voice, pacing, and word choice to cut through problematic interactions. Crisis induction is used to challenge the family to confront conflict or problems by staging a conflict or problem and welcoming the family to acknowledge and address it. The homeostasis of families that are chronically avoidant of conflict or problems is interrupted in order to help the family experience new patterns of interaction and relating with one another. Unbalancing is a method of realigning boundaries by the clinician inserting themselves into the family system. The clinician temporarily plays the role of an advocate by stating the family member or subsystem's case or help explain their view.

Making compliments and shaping competence. Making compliments and shaping competence help bring focus to the family's strengths and natural positive interactions. Specifically, making compliments is an intervention where the clinician encourages and reinforces behaviors that bring the family closer to meeting their goals. When shaping the family's competence, the clinician highlights and brings attention to small successes throughout the treatment process. This also includes using discretion in clinician involvement in session so as not to function for the family.

Case Examples

The following are vignettes for practice in utilizing the core components of SFT -

boundary assessment, understanding the parental hierarchy, identifying the role of the symptom, and implementation of SFT interventions.

- Jane is a 15-year-old female presenting in therapy with her mother and stepfather due to various symptoms of depression and significant problems with social interaction, impulse control, and emotion regulation. She lives with her parents and 11-year-old brother, who is the child of her mother and stepfather. Jane's biological father is present in her life but sees her twice a year during school holidays due to living out of state (Jane's mother and he were never married). Jane's parents report that they were concerned about Jane's behavioral issues at school and home as well as cutting behavior they recently discovered. Jane expresses frustration at "always" being blamed for their family problems and being punished for things her brother does not. She reports that her brother instigates a lot of their fights and irritates her on purpose to get her in trouble. She also adds that her mother is extra hard on her and doesn't allow her to make mistakes while her stepfather tries to support her side but ultimately goes with what her mother decides. Jane's stepfather notes that he has noticed that Jane's mother has always had high expectations for Jane stemming from when she raised Jane as a single mother before their marriage when Jane was 6-years-old. Jane's mother states that she had to be strict with Jane because she always had problems with emotion regulation and impulse control.
    - Boundaries
        - Identify the family rules for relating to one another.
        - Assess for the type of boundary that best describes the family

(e.g. clear, enmeshed and diffuse, or disengaged and rigid), including the rationale.

- Parental Hierarchy
  - Identify the parental subsystem of this family.
  - Assess the parental hierarchy (e.g. effective, insufficient, or excessive), include the rationale.
- Role of the symptom
  - Identify the relational position of the family system (e.g. ineffectual challenger, shaper, or beneficiary).
- Interventions (Describe an example of utilizing each of the following interventions below with the family.)
  - Enactments
  - Challenging the family's certainty and worldview
  - Unbalancing
  - Expanding the family's truths and realities

- John, a 17-year-old male, presents in therapy with his parents who brought him to address his recent dropping out of high school and suicide attempt two weeks ago. His parents state that their family had moved last year and John began attending a new school. They report that his behavioral issues, which include moodiness, outbursts of anger, poor grades, and isolation, began around that time. Before the move, John's parents state that prior to the move, John was a "normal child" - he did well in school and had a few close friends who would occasionally spend time at their home. When asked about other changes since

the move, John's parents indicate that they have both been working longer hours, which, along with John's behavioral issues, has strained their relationship. John reports that his parents argue frequently and he often listens to his music loudly to tune out their verbal arguments. John adds that he feels ignored and invisible most of the time to his parents and has had difficulty adjusting to his new school and neighborhood. John states that he tries to address his difficulty at his new school with his parents but his father responds with yelling at him, which prompts his mother to get angry at his father in defense of John. This increases tension between John's parents with John's father eventually leaving the house frequently to avoid arguments with John's mother.

- Boundaries
  - Identify the family rules for relating to one another.
  - Assess for the type of boundary that best describes the family (e.g. clear, enmeshed and diffuse, or disengaged and rigid), including the rationale.
- Parental Hierarchy
  - Identify the parental subsystem of this family.
  - Assess the parental hierarchy (e.g. effective, insufficient, or excessive), include the rationale.
- Role of the symptom
  - Identify the relational position of the family system (e.g. ineffectual challenger, shaper, or beneficiary).

- Interventions (Describe an example of utilizing each of the following interventions below with the family.)
    - Enactments
    - Challenging the family's certainty and worldview
    - Unbalancing
    - Expanding the family's truths and realities

Research Support

"Although no manual has been created to make [SFT] an empirically supported treatment, the components of structural therapy have been used in many empirically supported treatments, especially those targeting youth" (Gehart, 2010). Some of these evidenced-based treatments include Brief Strategic Family Therapy, Ecosystemic Structural Family Therapy, Functional Family Therapy (FFT), Multisystemic Family Therapy (MFT), and Multidimensional Family Therapy (MDFT) (Gehart, 2018; Henggeler & Sheidow, 2012; Radohl, 2011). Of these SFT-rooted treatments, FFT, MDFT, and MFT are considered Level Two Family-based Treatments by the Society of Clinical Child and Adolescent Psychology (SCCAP). Accordingly, discussion of literature supporting the use of SFT for the family-based therapy component of the SOAR program will include literature on SFT as well as literature on therapies rooted in SFT as they utilize key elements of SFT.

Studies examining the efficacy of SFT in the treatment of adolescents experiencing distress endorsed the utility of addressing systemic issues through the tenets of SFT. In a study of 189 participants within the age range of 18-55 years old and with

the average first incident of self-injury being 13 years old, Halstead et al. (2014) found that unhealthy family dynamics were positively correlated and associated with increases in self-injury behaviors. Specifically, healthy family dynamics were linked with decreased duration, frequency, periodicity, and severity of self-injurious behaviors. Lindahl, Breman, and Malik (2012) reported that examination of 270 couples with a child between the age range of 6-12 years old indicated that family boundary disturbances were correlated with emotional reactivity and child adjustment. The results suggest that interventions targeting positive youth adjustment should include boundary realignment, adjustment of communication patterns, and training in coping skills for emotional reactivity.

Therapies rooted in SFT such as MFT, MDFT, and FFT have also suggested that SFT interventions have significant effects in decreasing adolescent self-destructive behavior and emotional disturbances. Social ecology theory is the theoretical basis of MFT (Henggeler & Sheidow, 2012). Fundamental interventions utilized in MFT include realignments of boundaries and attention to maladaptive and repetitive family interactional patterns. A study evaluating the efficacy of MFT in decreasing suicide attempts among predominantly African American adolescents found that MFT was effective in reducing suicide attempts one-year posttreatment (Huey et al., 2004). In a study of 113 youth presenting with psychiatric emergencies, MFT was found to be more effective in stabilizing youth in crisis compared to hospitalization (Schoenwald, Ward, Henggeler, & Rowland, 2000). Other studies found that MFT was effective in significantly decreasing behavioral problems and symptoms, increasing positive family

and peer relations, decreasing serious emotional disturbances, and increasing functioning (Borduin, Schaeffer, & Heiblum, 2009; Stambough et al., 2007).

MDFT treatment uses a multisystemic orientation to target change in adolescents, parents, family environment, and other influential systems (Liddle, 2002; Rowe, 2012). Interventions rooted in SFT include the realignment of family hierarchy and use of enactments (Carr, 2016). The majority of research on the efficacy of MDFT is focused on its effects on the treatment of adolescent drug use. In addition to the significant reduction in drug use, studies show that adolescent treatment using MDST interventions also show improved functioning in various domains with gains maintained posttreatment (Liddle et al., 2009). Other studies have shown that MDFT is efficacious in decreasing behavioral and emotional problems (Liddle, 2015; Rowe, 2012).

FFT is a therapy based on a multisystemic viewpoint and utilizing core SFT interventions such as a focus on relational connectedness and hierarchy as well as realigning problematic relational patterns (Alexander & Parsons, 1982; Gehart, 2018). Most studies assessing the efficacy of FFT are also focused on adolescents engaging in risky and self-destructive behaviors such as substance use. However, findings indicate that FFT interventions significantly reduce risky behavior in adolescents (Waldron, Slesnick, Brody, Turner, & Peterson, 2001; Slesnick & Prestopnik, 2004; Slesnick & Prestopnik, 2005).

CHAPTER FIVE

TREATMENT MANUAL FOR SOAR FAMILY THERAPY

Participants

Adolescents and their guardian(s) are invited to participate in up to six family therapy sessions after they meet criteria for graduating from SOAR 2.0. Other immediate family members may participate after consultation with the clinician and family members on whether inclusion would be beneficial for meeting family therapy goals.

Program Goals for Family Therapy

The objective of the SOAR family therapy sessions would be to decrease the adolescent's self-injurious behaviors and maintain the adolescent's progress through family-focused treatment goals: addressing systemic issues that influence or may trigger the adolescent's self-injurious behaviors, providing support for the family system to increase healthy functioning as a whole, addressing issues impeding the use of DBT skills, supporting the parent(s) or guardian(s) by addressing parental hierarchy and boundaries so as to enable the parent(s) or guardian(s) to stay emotionally connected to their adolescent while maintaining appropriate boundaries, and addressing invalidation.

Session Format and Structure

The SOAR family therapy sessions are formatted to meet treatment goals within four to six sessions. Time between sessions will differ depending on the phase of treatment and clinician discernment. However, the set structure sets the time between the

first three sessions for one week, time between any other working phase sessions for two weeks, and time between the final working phase session and the termination session for three weeks. Each session is set to be approximately 50 minutes but time may be adjusted to be longer based on need and appropriateness, which will be decided by the clinician's discretion with family input.

Introductory Phase

The first session of SOAR family therapy is the introduction phase, which aims to introduce the purpose and format of the family sessions. The clinician will also check on DBT skills use at every session and provide appropriate support as needed. The clinician goals in this session include boundary assessment, identifying the symptom role, goal setting, and addressing expectations.

Session Outline

- Introduction of family sessions: purpose and format.
- Boundary assessment and identifying the role of the symptom.
- Explore and set clear goals and address expectations (family and clinician)
- Discuss the importance of homework between sessions, assign appropriate homework, and address barriers to therapeutic work outside of therapy
- Check on family's reactions to the session and address any remaining questions or concerns.

Clinician Goals

The clinician tasks include the following:

- Track family interactions and look for maladaptive patterns.
- Map family boundaries and hierarchy.
- Invite the family to act out interactions (directly or observing spontaneous enactments).
- Explore and set clear goals.
- Explore and discuss family and clinician expectations of treatment.
- Assign homework tailored to address the family's specific boundary and hierarchy issues.
- Follow-up on DBT skills use.
- Family check-in and address any questions or concerns.

Working Phase

Sessions two and three is the working phase. In these sessions, the clinician will introduce and invite the family to practice enactments. Other supportive activities will include setting clear boundaries, establishing the parental hierarchy, and checking on DBT skills use. Clinicians have the option of extending the working phase up to session five as appropriate to meet the needs and goals of the family.

Session Outline

- Review and process homework.
- Conduct enactments. Utilize appropriate interventions discussed under *Clinician*

goals to work on problematic boundaries and hierarchies.

- Evaluate and support continued DBT skills use.
- Discuss homework assignment and address barriers to therapeutic work outside of therapy.
- Check on family's reactions to the session and address any remaining questions or concerns.

Clinician Goals

The clinician tasks include the following:

- Utilize interventions to encourage change towards family goals.
- Assign homework tailored to address the family's specific boundary and hierarchy issues.
- Follow-up on DBT skills use.
- Family check-in and address any questions or concerns.

Termination Phase

The termination phase will address any remaining minor issues, reflect on progress, and may include a ritual component commemorating the completion of the family sessions.

Session Outline

- Review and process homework.
- Review and reflect on treatment experience and content.

- Evaluate and support continued DBT skills use.
- Set future goals and strategies to meet them (includes reinforcement of continued DBT skills use as appropriate).
- Ritual component (optional) – the guardian(s) and/or adolescent is invited to speak to current SOAR adolescents and guardian(s). The family is invited to process this experience in session (may be done in a separate continued termination session or assigned in a previous session to be processed in one termination session).

Clinician Goals

The clinician tasks include the following:

- Review experience in treatment and progress.
- Identify future goals.

CHAPTER SIX

CLINICIAN'S GUIDE TO TREATMENT MANUAL

Clinician Goals

The following are the goals with expanded explanations and specific tasks for the clinician working with the families in each phase of treatment.

Introductory Phase

The clinician tasks include the following:

- Track family interactions and look for maladaptive patterns such as over-connectedness, extreme disconnection, confusion in the family hierarchy (refer to *boundary assessment*).
- Map family boundaries and hierarchy with close attention to identifying areas for change.
- Invite the family to act out interactions (directly or observing spontaneous enactments). Prompt enactments when one does not happen spontaneously by asking, "Re-enact what happened [insert recent time conflict or problematic interaction occurred (this morning, last night, last weekend, etc)]," "Please show me what typically happens at home when [insert symptom or problematic behavior (adolescent is defiant, breaks rules, self-harms)]," or "So I can have a better idea of what the problem is, please act out a recent time [insert problematic behavior] happened."
- Informed by observation of enactments, tracking, and mapping, explore and set

clear goals. Overarching goals include setting clear boundaries, establishing the parental hierarchy, and reinforcing continued DBT skill use. More family-specific goals could also be set with the collaboration of the clinician.

- Explore and discuss family and clinician expectations of treatment. Clinician expectations of the family include completion of homework, open and honest participation in session, respect for each family member and the therapeutic process.
- Assign appropriate homework to engage in between sessions that reflect the family's specific boundary and hierarchy issues. Suggestions for post-introductory session homework include setting goals, thinking about problematic interactions, relational issues, and negative family dynamics.
    - Assess for any barriers to completing homework assignments and problem-solve to increase the probability of homework completion and treatment effectiveness.
    - Emphasize the importance of engaging in work outside of sessions in meeting treatment goals.
- Evaluate and support continued DBT skills check. Reinforce key skills learned and practiced in the SOAR program to maintain progress achieved through the program.
- Check on the family's reactions to the session and address any remaining questions or concerns. Brief time spent at the end of the session giving the family to express their experience of treatment will help inform any adjustments if indicated.

Working Phase

The clinician tasks include the following:

- Utilize appropriate interventions to encourage the change process towards meeting desired goals.
    - Invite the family to enact interactions (directly or observing spontaneous enactments). Prompt enactments when one does not happen spontaneously by asking, “Re-enact what happened [insert recent time conflict or problematic interaction occurred (this morning, last night, last weekend, etc)],” “Please show me what typically happens at home when [insert symptom or problematic behavior (adolescent is defiant, breaks rules, self-harms)],” or “So I can have a better idea of what the problem is, please act out a recent time [insert problematic behavior] happened.”
    - Redirecting alternative transactions using the following methods according to the interaction that is targeted for change: intervene on family members interrupting each other or speaking for one another, prompt two specific members to directly engage with one another while having other members allowing for the communication to occur without interruption, target disengagement by encouraging family members to emotionally understand and connect with each other, physically alter the configuration of the room (e.g. chair placement) to increase or decrease emotional attachment, invite parents or guardians to actively establish an effective parental hierarchy.
    - Utilize boundary making to soften boundaries that are rigid or strength

boundaries that are diffuse. Types of directives that can be used to achieve this are: altering seat positions, changing seats of family members to alter proximity and direction in relation to one another, strengthen subsystem boundaries through separate individual or subsystem sessions, requesting silence as needed during interactions, highlights a problematic boundary through inquiring about certain interactions ("do you always speak for your adolescent when they are asked a question?"), and supporting less dominant members to speak up by blocking interruptions or reinforcing appropriate pauses.

- Address and challenge problematic family certainties and worldviews. Some typical assumptions or worldviews that the family holds that lead to problems and should be challenged are: the kids have to come first, keeping the peace is most important, individual needs are less important, it's easier to sacrifice individual needs than ask for them to be met, if I compromise on this then you must compromise as well, it's better to stay in an unhappy marriage than face the consequences of a divorce.
- Expanding the family's truths and realities focus on existing beliefs and expand them so it can now reinforce the work towards therapy goals. Examples of this includes statements like, "It's obvious that you really care about your child, so I know you're probably willing to help them in more challenging ways such as letting them make their own mistakes" or "Since you have done so much already to try and help your child, I know that you're able to understand that your child probably needs some space

to grow and really thrive." Utilizing existing beliefs allows the family to hold onto what is already familiar to them but apply them in a novel way.

- Intensity inductions are recommended if the family is having difficulty accepting other interventions. The clinician intensifies emotional reactions by manipulating their tone of voice, pacing, and word choice. Examples of this would be the clinician telling a couple subsystem that insists on not having time for themselves because of their responsibilities with their children, "Would your children prefer to have all their activities and have parents who are constantly in conflict or disengaged or have fewer activities and have parents who have a great relationship?"
- Crisis inductions can be used for chronically avoidant families. Induce the problem and invite the family into an enactment requiring them to face this problem. The clinician can guide the family in exploring alternative responses during the enactment, which can help the family experience a new understanding of interactions and patterns. An example of a substance use problem would be to stage an interaction that the substance use issue would surface and have the family acknowledge and address the issue.
- Unbalancing is recommended when there are particularly difficult hierarchies or when a specific family member who is being scapegoated. To address these more challenging hierarchies or scapegoating, the

clinician joins with a family member who is often scapegoated or to give more support to a subsystem that needs help strengthening boundaries. The clinician temporarily plays the role of an advocate by stating the subsystem or family member's case or help explain their view. When the clinician inserts themselves in such a way, it must be done so with a clear goal in mind that targets realignment of boundaries and hierarchies and should be used sparingly.

    - Making compliments and shaping competence uses positive statements and reflections on even small differences in family interaction and patterns to provide encouragement and build confidence in the family. In particular, it is important to pay attention to shaping confidence by not being overtly involved in the family interactions. Instead of stepping in directly to make adjustments, the clinician should direct family members to make those adjustments when appropriate. For example, the clinician to direct the parent to ask the adolescent to focus or correct the adolescent. Another example would be to prompt the adolescent to clarify what they mean to communicate if the clinician notices a problem in communication.

- Assign appropriate homework to engage in between sessions that reflect the family's specific boundary and hierarchy issues. Reasonable homework assignments are specific, realistic activities that help to increase interactions in disengaged families or reinforce clear and healthy boundaries in enmeshed families.

    - Assess for any barriers to completing homework assignments and problem-solve to increase the probability of homework completion and treatment effectiveness.
    - Emphasize the importance of engaging in work outside of sessions in meeting treatment goals.
- Evaluate and support continued DBT skills use. Reinforce key skills learned and practiced in the SOAR program to maintain progress achieved through the program.
- Check on the family's reactions to session and address any remaining questions or concerns. Brief time spent at the end of the session giving the family to express their experience of treatment will help inform any adjustments if indicated.

Termination Phase

The clinician tasks include the following:

- Invite the family in reviewing their experience in family treatment and progress. Some key factors to review are important concepts and skills that have been worked on in sessions, the family's good hard work that has led to progress and positive changes, credit to the family for their strength and courage to make meaningful change, and reminder that maintenance of progress and continued success depends on the continued practice of skills learned in therapy.
- Collaboratively identify goals moving forward and outline specific strategies that will be used to meet those goals. Reinforce the idea that the family has the

tools to be their own clinician and are capable of meeting future challenges.

Cultural Considerations

When assessing the family boundaries, parental hierarchy, and the symptom's role in the family, careful consideration and sensitivity to cultural factors are imperative. Clinicians should take care not to pathologize cultural norms and spend time exploring each family's cultural factors that may inaccurately skew clinical assessments toward problematic boundaries, hierarchies, and symptoms roles. Collaborating with the family throughout the treatment process will help with the appropriate considerations of cultural factors.

Other Considerations

There are various issues that may need special consideration. In DBT-A treatment, the issue of difficult or resistant parents is dealt with through skills training and psychoeducation in the early stages of treatment. However, if there is resistance or difficult parents specifically with regards to the family therapy portion of treatment, it can be dealt with the same DBT skills and additional psychoeducation about the purpose and benefit of family therapy at this stage of treatment. Non-traditional family configurations such as mixed families, grandparents as the primary guardian, or multifamily households can also require special considerations in conducting family therapy. Close collaboration and communication with the family is needed to determine how family therapy will be formatted and address issues such as which family members will be present and what issues are most salient to the greater treatment goals of the adolescent decreasing

maladaptive behaviors and increasing their sense of well-being. In situations where the family is trying to deal with particularly sensitive therapeutic issues surrounding the adolescent such as gender identity or sexual orientation, therapists should seek supervision and consultation on how to address these issues. Particular sensitivity and care is required with identity issues and, as with any other clinical issues, it is imperative to seek appropriate supervision if the clinician has limited clinical knowledge of or experience with the topic, consultation, or referral.

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FOOTNOTES

[1]The full list of Level Two criteria therapies include individual Cognitive Behavioral Therapy (CBT) with family CBT and parent training for suicide attempts, Family-Based Therapy (FBT) including parent training only for suicidal and non-suicidal self-injurious thoughts and behaviors, attachment-focused FBT for suicidal ideation, individual Interpersonal Therapy for suicidal ideation, and individual Psychodynamic Therapy with family involvement for deliberate self-harm (Southam-Gerow & Prinstei, 2014).

[2]Family-based Treatments include Family-based Behavioral Treatment, Family-based Behavioral Treatment – Parent only, Functional Family Therapy, Multidimensional Family Therapy, and Multisystemic Therapy (Society of Clinical Child and Adolescent Psychology, 2017).