Functional Family Therapy Child Welfare

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Core Philosophy

• Respectfulness
• Non-judgmental
• Strength-based

Family-Based

• Balanced Alliances
• Relational vs. Individual
• Matching to individuals, relationships, family, and environment

Risk and Protection

• Altering ratios or odds by reducing risk and enhancing strengths
Adaptations for Child Welfare

- Triage process to “match” typical child welfare workers skill sets and families needs (cost sensitive approach to work with full range of referrals)
- Expanded age range for treatment focus; inclusion of developmental considerations across the age range
- Formal expansion of treatment targets to include ALL family members
Treatment Parameters

- **Research-based** prevention and intervention program for children, adolescents, and families
- **Targets** children and youth of all ages....
  - Prevention intervention—General preventative/Teen Preventive
  - Treatment intervention-FTR
- **Short-term, family-based** program
  - 8-13 for moderate cases, 26-30 for more serious cases spread over 3 to 6 months
- **Range of problems**
  - Violence, drug abuse/use, conduct/criminal behaviors, family conflict, abuse, neglect, mental health
Clinical problems falling under the label “Internalizing and Externalizing Behavior Disorders for children, adolescents, and adults”

- Conduct disorder
- Oppositional defiant disorder
- Drug use/abuse
- Other behavior problems…violence, school problems, truancy, etc.
- ADHD

Other mental health problems
- Anxiety/depression with behavior disorder symptoms expressions

Parent-child/family conflict issues
MATCHING (a philosophy as much as “a technique”) is a fundamental requisite for effectively engaging and changing families

“Match to” clients:
Working hard to respect and understand them, their language, norms, etc

In the Early Phases it is “all about them”
Referral Considerations

Inclusion Criteria

- Families with children and youth 0-18 years old
- In community or ready to go into the community
- Family available
- Youth is returning to family
- Inclusionary referral behaviors include externalizing behaviors, internalizing symptoms, and/or substance abuse
- Referral issues can be from one domain (externalizing alone) or in combination (co-morbidity of substance abuse and externalizing behaviors) of both the children, youth, and parents
Referral Considerations

Exclusion Criteria

- Youth who have no psycho-social system that constitutes family (shared history, sense of future, some level of co-habitation)
- Youth is scheduled to be sent away from family (remand, placement, foster care, etc)
These categories do not automatically represent an exclusion and can be considered:

- Youth and/or parents that present with severe psychiatric illness:
  - actively suicidal
  - actively homicidal
  - actively psychotic

- Youth and/or parents with developmental delays/cognitive impairments
The FFTCW Therapist

- Primary focus is on the safety and well being of the children and adolescents
- Expectation to assess safety and risk issues ongoing through the course of treatment and effectively intervene in order to eliminate and/or minimize these factors
- Function as both a therapist and case manager as seen by the CW system
- Need to maintain model fidelity and meet expectations of child welfare system
They are responsible to recommend or facilitate removal of children when necessary. They have ultimate responsibility and accountability for what happens with and within the family.

CW systems often drive case managers to be hyper-vigilant, to err on the side of safety, which can mean being problem driven and reactive.
Addressing Safety and Risk Issues

- FFTCW therapist must assess if there is any safety and risk issues within the family that would warrant a level of abuse, neglect, maltreatment to the children.
- This also includes assessment of basic physiological and developmental needs of children and adolescents.
- It requires awareness, observation, and knowledge of developmental milestones and indicators of abuse/neglect/maltreatment/violence.
Immediate Versus Longer Range Safety Issues

- During the first few sessions, you must distinguish between “safety issues” that
  - must be addressed (as in plans & limits imposed) immediately – even if it sacrifices your long term ability to continue to work with the family
    - Versus
  - Can wait until later in this session
    - Versus
  - Can wait until later sessions (e.g., sessions 3, 4 & beyond) to be addressed so you can first establish bonding and motivation to change
Engagement Phase

**Goals**
- Enhance perception of responsiveness and credibility

**Skills**
- Superficial qualities
  - Persistence
  - Matching

**Focus**
- Immediate responsiveness
- Strength-based and relational

**Activities**
- Availability
  - Phone reach out, Frequency

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Functional Family Therapy
Motivation Phase

- Create context for change
- Decrease conflict
- Increase hope
- Balanced Alliances

- Strength-based
- Relational
- Non-judgmental
- Respectful

- Interpersonal
  - Clinical
  - Contingent
  - Responsive

Focus

Goals

Activities

Skills

- Change Focus
- Change Meaning

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FFT Functional Family Therapy
Developmental Considerations

- Infant/Toddler/Pre-Schooler/Primary School Child/Preadolescent/Adolescent status is important
  - Heavily influences the family structure that is the desired endpoint of intervention
- Important to “match-to-sample” based on developmental level as well as relational functions


**Early Spacing of Sessions**

The spacing, or number of days between the first, second, and third FFT sessions, depends primarily on:

1 - the severity of risk factors
2 - the immediate availability of protective factors
3 - your overall judgment of how long the family can go without a major disruption.

*With high risk families we would expect 3 sessions in the first 10 days of FFT*
Who Are The “Major Players”?

1 – Family member(s) seen as part of the “problem” according to referral source(s).

2 – Family members we think (based on referral info and first calls to the family) are likely to “shut the process down” - and who probably can!

3 – Family members we think are necessary to begin change

4 – Important larger family system members (e.g., grandmother) or involved support systems (e.g., mother’s best friend & neighbor) who will participate and are “appropriate” participants vis-à-vis retaining a highly influential role with the youth / family.
Who Are The “Major Players”

With respect to young(er) children:

2 – Family members we think are likely to “shut the process down” - and who probably can!
   AS OPPOSED TO “CAN ONLY IF THE PARENT ALLOWS THEM TO."

3 – Family members we think are necessary to begin change.

   Question: DO YOU REALLY NEED TO GET A 6 YEAR OLD CHILD’S “PERMISSION” TO BEGIN TO CHANGE FAMILY PROBLEMS, ESPECIALLY IF IT IS TO HELP THE CHILD?
Examples of Theme Hints that can lead to Themes/Reframes

• Anger implies (underlying) hurt or loss
• “Guilt” theme
• Depression = not “giving up” on others
• Defensive behavior reflects emotional links
  - “You don’t know how lucky you are!”
• Nagging reflects importance
• Pain interferes with listening
• Frightened by differences
• Need to feel OK about self in context of problems
  - Even if what I’m doing doesn’t “work”
• Protection
• Giving up so much power to someone else
• Youngest / oldest …. Trying to “fix” parent(s)
Examples of Reframes, Theme Hints, & Relational Themes

- anger implies (underlying) hurt
  - anger implies loss
  - “guilt” theme
- Depression = not “giving up” on others
- defensive behavior reflects emotional links
  - (“you don’t know how lucky you are!”)
  - nagging reflects importance
  - pain interferes with listening
    - frightened by differences
- need to feel OK about self in context of problems ....
  - (even if what I’m doing doesn’t “work”)
    - protection
  - giving up so much power to someone else
- Youngest / oldest .... Trying to “fix” parent(s)
Examples of Reframes & Relational Themes (Younger kids)

“Out of control” = that could be the child saying: “Mom, I’m going to keep this up until you get help … you can’t do all this alone”

Fire setting = “I’m going to make it clearer and clearer that I need limits – you still don’t seem to “get it.”

(Therapist): Did you (Mom) know that kids think their Moms are more troubled when they are confused than when they are really angry? For all I know, he (high problem behavior kid) might think he is helping you focus. That is pretty “stupid” I know, but 7 year olds are “stupid” in that way… though I’d rather use the word “misguided” rather than stupid of course.” You may seem to feel less sad when you are angry than when you are just being you.
Relational Assessment Phase

 Goals

 - Formulate relational assessment
 - Plan for behavior change

 Skills

 - Perceptiveness
 - Understanding systems and relationships

 Focus

 - Within family patterns
 - Extra-familial patterns

 Activities

 - Elicit and analyze information about patterns
 - Observation

 FFT
 Functional Family Therapy
but the functional-relational pattern it represents…. behaviors and their possible interpersonal (relatedness) functions (adult & adolescent).

**Autonomy: distance, independence, separating, (Fear of Enmeshment?)**

- **High**
  - Being cold, sarcastic, withdrawn passively
  - Teenage runaway
  - Communicating less emotionally, indirectly but positively
  - Having many jobs and outside activities

- **Low**
  - Being depressed
  - Visible self mutilation
  - “Ideal” balanced adult
  - Teenage runaway

**“Positive” Behaviors**

- Giving considerable nurturance, warm & loving
- Having many jobs and outside activities

**“Negative” Behaviors**

- Adol Substance Abuse (pseudo-individuation)
- “Borderline” behavior
- Visible self mutilation
- “Ideal” balanced adult
- Teenage runaway

**Contact: closeness, dependency, enmeshment, (Fear of Abandonment?)**
Examples – older children

**Autonomy:**
- distance
- independence
- separating,
  (Fear of Enmeshment?)

**High:**
- Sullen withdrawn
- Things rather than people
- (Preference for) Prosocial interests outside of home

**Low:**
- Dependent, clinging

**Self Directed (prosocial):**
- Sharing family activities

**Oppositional:**
- Secretive but dangerous behavior
- Impulsive disrespectful

**“Positive” Behaviors**
-ード

**“Negative” Behaviors**
- Dependent, clinging,
  (Fear of Abandonment?)

Contact: closeness, dependency, enmeshment,
Behaviors and their possible interpersonal (relatedness) functions Ages 0–6 (think Attachment Theory)

- **Autonomy:**
  - **High:**
    - Interacts well w/ nonfamily members
  - **Low:**
    - Unresponsive or Actively avoidant
    - Withdrawn
    - Self play, Exploration

- **Contact:**
  - Closeness, dependency, enmeshment
  - "Positive" Behaviors
  - "Negative" Behaviors

- **Attention:**
  - Demanding but rejects attention
  - Alternates autonomy and connection
  - Inconsolable

- **Open, Smiley, "cute"**
  - "Needy," clinging, demanding

(Fear of Abandonment?)
Who Needs To Be “Reframed”

All family members who are the object of blame and negativity (including “self”, i.e. the guilty parent)
How Can You “Get Control” of a Misbehaving Youth if the Parent Isn’t One-Up?

Interpersonal control is an issue that may have as much to do with the quality of a relationship as it does with “Power”
FFT believes it also is important to understand family members can exert control through relational connection and the *quality of the relationship*.

- FFT works hard to create family bonding so that youth “obey” parents because they “love” and want to please them.
- When parents and youth have more positive “feelings” about each other, and if they share increased hope for change and less blaming and negativity, FFT therapists find cooperation, mutual support, and family members’ ability and willingness to try new behaviors to be increased dramatically.
“Influence” is not necessarily Fear and “Control” based, any more than is “Respect.” Programs that feel they can only help parents “control” the youth through negative consequences and “one-up power” can fall prey to the same limited influence systems as violent youth who equate “power” and “respect” with creating fear and negative consequences.
Transitioning from Motivation to Behavior Change

- Have you met your goals of motivation?
  - Have you been able to change meaning with the family regarding the problem?
- Have you assessed relational functions and hierarchy?

If you can answer yes to the above, then you are ready to move into Behavior Change
Behavior Change Phase

- Eliminate referral problems
- Improve family interactions
- Build skills

Goals

- Directive
- Teaching
- Structuring

Skills

- Facilitating tasks
- Modeling / Coaching
- Homework

Activities

- Changing behaviors and interactions
- Compliance

Focus

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Risk Factors

- Early Aggressive Behavior
- Lack of Parental Supervision
- Parent Substance Abuse
- Drug Availability
- Poverty

Domains

- Individual
- Family
- Peer
- School
- Community

Protective Factors

- Self Control
- Parental Involvement
- Academic Competence
- Anti-drug Use Policies
- Strong Neighborhood Attachment

Cellular to Social Context
Frequently Addressed Risk Factors w/Parents

- Inconsistent parenting (not matched to what the kid needs) and even care-giver source
- Violence/abuse (as a reaction and/or coercive?)
- Parental mood / anxiety disorders
- Parental substance abuse
- “Parental” high conflict low resolution
- Inflexibility in parent match w/developmental stage of changes
- External system pressure on parents; economic, etc
Frequently Addressed Risk Factors with CW Involved Younger Kids and Adolescents

- Mood Disorders (Depression, Anxiety)
  - Suicidal ideation or history
  - Pattern of self harm (cutting)
- Substance Use
- Involvement in Juvenile Justice System
- Out-of-home placement history (mental health, juvenile justice)
- Truancy and Running Away behavior
- Parenting and/or pregnant teens
Frequently Addressed Risk Factors with CW Involved Younger Kids and Adolescents (continued)

- History of physical and/or sexual abuse or other significant trauma
- High physiological (CNS, etc) kid risk – including temperament and impulsivity
- Older sibings / peers who use substance (delinquent)
- Poor parent-child attachment
- Inability (“congenital” or “learned”) to self manage impulses and emotions
Developing a Behavior Change Plan

- Review the Family Behavioral Pattern
- Review Risk and Protective Factors
- Identify the skill deficits and skill strengths of family
- Identify the specific skills you want to address with each family member
- Determine how to best teach that skill based on relational functions, hierarchy, family learning style, family interests
Family Interaction Targets

- Communication Training
- Problem Solving
- Negotiation
- Contracting
- Reinforcement (Punishment)
  - Token economy
  - Contingency Management
  - Response Cost
- Monitoring

Developmentally appropriate
Family specific
Accommodate to functions
Further BC Planning Considerations
Family Well Being: Parent and Child

- Understanding Risk and Protective factors that impact family functioning
- Understanding that the parent may not be able to take a greater role of power or responsibility due to overwhelming risk factors of mental health, substance use/abuse, lack of resources, autonomy needs
- Focusing on overall well being of family members by first looking at how the symptoms are part of family relational patterns
- Assess where to begin Behavior Change interventions and understand when need to incorporate relevant resources