

**A TYPOLOGY OF FAMILY FUNCTIONING IN A CHILD AND ADOLESCENT
OUTPATIENT COMMUNITY MENTAL HEALTH TREATMENT FACILITY**

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Submitted to the Graduate Faculty of
University of Pittsburgh, School of Education in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

University of Pittsburgh

2012

UNIVERSITY OF PITTSBURGH
SCHOOL OF EDUCATION

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Kathleen Elizabeth Davies, Ph.D.

University of Pittsburgh, 2012

Current estimates suggest that 16% to 22% of children and adolescents in the United States are diagnosed with mental health disorders, and nearly six million children and adolescents experience symptoms that interrupt their daily functioning (Chung, Edgar-Smith, Palmer, Bartholomew, & Delambo, 2008). Understanding the functioning of families seeking mental health services is imperative to tailoring services in order to meet their needs.

The purpose of the present study was to explore and describe the functioning of families as they initiate outpatient community mental health services in an effort to better understand their needs and ultimately to tailor the services to meet these needs. Two research questions were posed in the present study: 1) What typology of family functioning exists for families initiating outpatient services from a community mental health treatment facility, and 2) In what specific areas of family functioning are families obtaining unhealthy scores most frequently?

This study utilized an exploratory analysis, specifically a k-means cluster analysis, in order to identify and describe a typology of family functioning as perceived by families initiating outpatient mental health services. The findings suggest that three clusters emerged from the data including: 1) families who obtained healthy scores on all of the subscales on the measurement used, 2) families who obtained unhealthy scores on all of the subscales, and 3) families who obtained healthy scores on some of the subscales and unhealthy scores on others. Given that this study is a first in the field, the results have both pertinent research and clinical implications.

DEDICATION

To my daughter (Emma) and in memory of my father (John).

ACKNOWLEDGEMENTS

I would like to extend my heartfelt gratitude to the following individuals:

To my husband (Will): I hereby grant you an honorary Ph.D. in ADP. Thank you for your unending love and support. You are nothing short of a miracle and I look forward to sharing the rest of this journey with you. To my daughter (Emma): I cannot find the words to describe the happiness and joy that you have brought to my life. I thank God that He chose me to be your mommy. To my mother (Rose): When all odds seemed to be stacked against us, you demanded nothing less than my absolute best. Thank you for paving the way for me to become the person I am today. I would also like to thank all of my family members and friends who each continue to help support and guide me through all that life brings.

To my dissertation committee members (Dr. Klein, Dr. Johnson, Dr. Kerr, and Dr. Ye): Thank you so much for all of your support, guidance, and expertise throughout this process. I am so proud of this work and I know that it would not have been the same without your dedication to helping me see it through.

To the clinic administrators and staff: You are truly angels dressed as clinicians. I am continuously amazed at the work that I see in the clinic. Your service to others is inspiring and amazing.

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1.0 INTRODUCTION

1.1 STATEMENT OF THE PROBLEM

In July of 2008, the State Legislature of Nebraska passed Legislative Bill 157, which enacted a Safe-Haven law that enabled parents to leave their children at any hospital in the state and immediately renounce their parental rights (Bringewatt & Gershoff, 2010; Nebraska Department of Health and Human Services, n.d.). The intention of the law was to provide a safe alternative to child abandonment, because children who were left at hospitals were subsequently placed into state custody (Bringewatt & Gershoff, 2010). However, the regulations initially did not specify age limits of the child (Bringewatt & Gershoff, 2010). By the time the child age limit was passed, 30 of the 36 children placed into state custody were between the ages of 11 and 17 years (Bringewatt & Gershoff, 2010; Nebraska Department of Health and Human Services, 2008a). Among the 36 children and adolescents placed into state care, 30 had received prior mental health services and 11 had been hospitalized in an inpatient mental health facility (Bringewatt & Gershoff, 2010; Nebraska Department of Health and Human Services, 2008b). These statistics suggest that the families who had taken their older children and adolescents to hospitals for placement had attempted to obtain services to address mental health concerns (Bringewatt & Gershoff, 2010).

The devastating effects of mental health concerns on children and their families is evidenced in Nebraska's Safe-Haven Law example, but can also clearly be seen nationwide. Current estimates suggest that 16% to 22% of children and adolescents in the United States are diagnosed with mental health disorders (Chung, Edgar-Smith, Palmer, Bartholomew, & Delambo, 2008). Nearly six million children and adolescents experience symptoms that interrupt their daily functioning, and approximately 15,000 child and adolescent inpatient mental health beds are filled at any given time within the United States (Chung et al., 2008). The national cost for mental health treatment for children and adolescents is approximately 12 billion dollars (RAND, 2001).

Recently in a study of more than 10,000 adolescents between the ages of 13 and 18, researchers discovered that a significant proportion of the sample met criteria for a mental health diagnosis (Merikangas et al., 2010). Eleven percent of the participants reported severe symptoms of mood disorders such as depression, 10% reported severe symptoms associated with behavioral disorders such as attention-deficit/hyperactivity disorder, and 8% of the participants reported severe anxiety disorders such as generalized anxiety disorder (Merikangas et al., 2010). Approximately 40% of the participating adolescents who met criteria for one mental health diagnosis also met criteria for a co-occurring disorder (Merikangas et al., 2010). The researchers concluded that the proportion of adolescents living with a mental health diagnosis far exceeds the number of adolescents living with common physical conditions such as asthma and diabetes (Merikangas et al., 2010).

Many children and adolescents in the United States currently meet criteria for mental health disorders, and their families are initiating services to address these symptoms. Unfortunately, the mental health system has been described as "complex" and "fragmented,"

making the obtainment of appropriate services difficult (Bringewatt & Gershoff, 2010, p. 1291; Adams, Daniels, & Ries, 2005). Societal pressures (e.g., stigma) and psychosocial stressors (e.g., poverty) also impact a family's ability to locate and maintain participation in appropriate mental health services (Bringewatt & Gershoff, 2010; Fontanella, Early, & Phillips, 2008). The Institute of Medicine has recently expressed concern over the state of the medical and behavioral health care systems in the United States (Adams et al., 2005). The Institute of Medicine has recommended tailoring behavioral health treatment to meet the needs of individuals and their families in a timely and efficient manner using evidenced based practices (Adams et al., 2005). With the increased importance of managed care, clinical administrators offering family services in their outpatient facilities are urged to identify and implement treatment modalities that are effective and evidenced based, yet also cost effective (Hoagwood, Jensen, Petti, & Burns, 1996).

All clinicians offering mental health services link theory to practice, or tailor treatment options to the strengths and needs of their individual clients (Sperry, 2005). This link between theory and practice includes four steps: "1) comprehensive assessment; 2) matching a therapeutic strategy...; 3) tailoring the chosen strategy; and 4) implementation, review, and revision of the matching and tailoring efforts" (Sperry, 1993, p. 52). Specifically, if a family requests services for communication concerns, then the therapist will begin treatment by exploring the current communication practices in the family and will then work with the family to alter these practices in order to meet the treatment goal of improved communication.

Research also supports the practice of tailoring treatment options to the presenting problems of those initiating services. For instance, the practice of tailoring treatment based upon the needs of clients has been related to improved outcomes in many areas of treatment, including the treatment of alcoholism (Karno, Beutler, & Harwood, 2002), couples therapy (Sperry, 1993),

and family therapy (Sperry, 2005). However, all of the research regarding the tailoring of treatments has been directed toward individual clinicians as the primary audience and has focused on a specific diagnosis or set of symptoms (Figure 1). These studies have provided clinicians with information on how to tailor the treatment options they offer in their sessions based upon individual client factors, such as the client's perspective of the problem, the client's diagnosis, or the client's readiness for change. Therefore, there is currently a gap in the literature. No current research addresses clinical administrators who design the general services and programming offered at the outpatient clinics to families who present with a wide range of symptomatology. If clinical administrators were aware of the functioning of the families initiating services from their clinic, then they may be able to design and offer appropriate interventions.

Given that the mental health system in general has been described as "fragmented" (Bringewatt & Gershoff, 2010, p. 1291; Adams et al., 2005) and "complex" (Bringewatt & Gershoff, 2010, p. 1291; Adams, Daniels, & Ries, 2005), designing and offering services that are tailored to the functioning of the specific families initiating services may help families engage and remain in outpatient services. This may also decrease the cost of mental health services of children and adolescents as families would immediately receive appropriate services, thereby potentially decreasing the need for more intensive and expensive services in the future. Additionally, the use of particular treatment modalities, such as group interventions, may also help to reduce costs. For instance, if clinical administrators find that a majority of families initiating services are experiencing difficulty with communication, then a communication treatment group could be established. The reduction of costs would stem from a group of

families being seen by one therapist, versus each family having individual sessions with different therapists.

Research focusing on tailoring individual treatments (clinician level):	Research focusing on tailoring treatments offered at a clinic; (clinical administrator level):
<ul style="list-style-type: none">• "Cognitive Behavioral Therapy for Negative Symptoms" (Perivoliotis & Cather, 2009).• "Tailored Psychosocial Treatments for ADHD: The Search for a Good Fit" (Abikoff, 2001).• "Which Therapeutic Mechanisms Work When: A Step Towards the Formulation of Empirically Validated Guidelines for Therapists' Session-to-Session Decisions" (Smith & Grawe, 2005).• "Interactions between Psychotherapy Procedures and Patient Attributes that Predict Alcohol Treatment Effectiveness: A Preliminary Report" (Karno et al., 2002).• "Tailoring a Collaborative, Constructionist Approach for the Treatment of Same-Sex Couples" (Perez, 1996).• "Tailoring Treatment with Dual-Career Couples" (Sperry, 1993).• "Tailoring a Cognitive Behavioural Model for Unexplained Physical Symptoms to Patient's Perspective: A Bottom-Up Approach" (Zonneveld, Duivenvoorden, Passchier, & van't Spijker, A., 2010).• "Clinical Considerations when Tailoring Cognitive Behavioral Treatment for Young Children with Obsessive Compulsive Disorder" (Choate-Summers, Freeman, Garcia, Coyne, Przeworski, & Leonard, 2008).	<ul style="list-style-type: none">• No known research in this area exists.

Figure 1. The Audience of Research.

Another important component of understanding the functioning of families as they initiate services in order to design appropriate interventions is the importance of the timing of the

research. The majority of research completed on family functioning has been done longitudinally. For example, researchers have studied the effectiveness of services, such as community based treatment programs (Thornton, Stevens, Grant, Indermaur, Chamarette, & Halse, 2008), family interventions (Girón, Fernández-Yañez, Maóá-Alvarengam Molina-Habas, Nolasco, & Gómez-Beneyto, 2010; Sundelin & Hansson, 1999), and residential treatment facilities (Preyde, Cameron, Frensch, & Adams, 2011; Sunseri, 2004), in relation to family functioning and individual child mental health outcomes over the course of treatment. Additionally, researchers have studied family functioning as a predictor to a specified outcome, such as the engagement in services (Headman & Cornille, 2008) and the experience of mental health symptoms including depression (Feeny et al., 2009). However, few studies have examined the functioning of those initiating services with the purpose of using the descriptive data to design and implement tailored interventions. The few studies that have purposefully studied family functioning in order to guide treatment have, as previously discussed, used the information to make suggestions to individual clinicians. These data have not been used in an attempt to design services offered by a clinic and are specific to particular diagnoses. For instance, Sullivan and Miklowitz (2010) studied the family functioning of adolescents diagnosed with bipolar disorder. The researchers suggested that clinicians assess individual families for a number of factors such as the flexibility of the family system and apply tailored interventions as needed (Sullivan & Miklowitz, 2010). The study provided pertinent information on the treatment of families with adolescents who are diagnosed with bipolar disorder. However, information regarding the common areas of family functioning that are particularly difficult for families who are initiating services, regardless of a particular diagnosis, remains a missing component in the literature (Figure 2). This information could potentially help clinical administrators design

interventions tailored to the functioning of the families initiating services at a general outpatient clinic that offers services to children and adolescents experiencing a wide range of symptoms.

Research studying family functioning at the initiation of services:	Research studying family functioning as an initial predictor to a later outcome:	Research studying longitudinal effects of treatment in relation to family functioning:
<ul style="list-style-type: none"> •"Family Functioning Among Adolescents with Bipolar Disorder" (Sullivan & Miklowitz, 2010). •"Self-Perceived Family Functioning in 40 French Families of Anorexic Adolescents: Implications for Therapy" (Cook-Darzens, Doyen, Falissard, & Mouren, 2005). 	<ul style="list-style-type: none"> •"Predicting the Longitudinal Effects of the Family Environment on Prodromal Symptoms and Functioning in Patients At-Risk for Psychosis" (Schlosser et al., 2010). •"An Exploratory Analysis of the Impact of Family Functioning on Treatment for Depression in Adolscents" (Feeny et al., 2009). •"Family Functioning Patterns as Predictors of Enagagement: Which Families Participate in Services and Which Ones Do Not?" (Headman & Cornille, 2008). 	<ul style="list-style-type: none"> •"Parent-Child Relationships and Family Functioning of Children and Youth Discharged from Residential Mental Health Treatment or a Home-Based Alternative (Preyde et al., 2011). •"Family Functioning and Residential Treatment Outcomes" (Sunseri, 2004). •"Intrafamilial Adolescent Sex Offenders: Family Functioning and Treatment" (Thorton et al., 2008). •"Intensive Family Therapy: A Way to Change Family Functioning in Multi-Problem Families" (Sundelin & Hansson, 1999). •"Efficacy and Effectiveness of Individual Family Intervention on Social and Clinical Functioning and Family Burden in Severe Schizophrenia: A 2-Year Randomized Controlled Study" (Girón et al., 2010).

Figure 2. The Timing and Purpose of Research.

Understanding the functioning of families when they initiate mental health services is imperative for designing and implementing appropriate interventions. Establishing less complex treatments that are designed with the families' functioning in mind may increase the families'

ability to maintain participation in treatment. Unfortunately, many outpatient clinics are unaware of the needs of the families entering their clinics, leading to a mental health care system in “disarray” (Donaldson, 2005, p. 90) . In fact, such information that could assist program improvement is currently missing in the literature (Mark, Henry, & Julnes, 2000). Given managed care and the need for efficient yet effective services, clinical administrators must have an understanding of the level of functioning of the families initiating services in their clinics in order to tailor brief treatment interventions. Providing knowledge regarding the functioning of families initiating services in the community will help to fill this gap in the literature and can begin to assist community mental health centers in designing and implementing appropriate services.

1.2 THEORETICAL PERSPECTIVES OF FAMILY TREATMENT

1.2.1 The “Creation” of Family Therapy

The first generation of family therapy, also known as the period of the “pioneers and renegades” is associated with the time period prior to 1969 (Kaslow, 2000, p. 357). For all intents and purposes, professional family therapy was not identified as a mode of intervention prior to the 1940s (Beels, 2002; Gladding, 2002). There are several reasons for the scarcity of family therapy services during this time period. The culture of society during this time rewarded individualism, or promoted individuals who were able to work diligently and solve their problems privately (Gladding, 2002). Similarly, the predominant focus of services and interventions at the time was centered around behaviorism and psychoanalysis, which tended to focus on individual versus

family treatment (Gladding, 2002). For example, in his influential work, *The Ego and the Id*, Freud (1923) argued that all psychological symptoms are best understood as rooted within the internal conflict of an individual's primal desires, consciousness, and moral beliefs. Skinner (1938) also promoted the idea that human behavior is best understood in the context of environmental rewards or reinforcement. Given the focus on individuals in both society in general as well as the mental health field, few professionals during this time period practiced what is considered today to be family therapy.

The creation and growth of family therapy began in the 1940s and continued throughout the 1950s (Beels, 2002; Gladding, 2002). Several prominent individuals in the field and societal events helped the emergence and spread of family therapy as a mode of treatment. Nathan Ackerman, an eminent child therapist, began the private practice of treating families and teaching this practice to other professionals in the field in the 1940s (Beels, 2002; Ackerman, 1958; Ackerman & Sobel, 1950). Ackerman wrote multiple books and articles on how to incorporate the family into individual practices and shared successful case examples at professional conferences (Gladding, 2002; Ackerman, 1958; Ackerman & Sobel, 1950). In the mid-1950's, Murray Bowen also established a unit at the National Institute of Mental Health devoted to observing and documenting the familial interactions of individuals diagnosed with schizophrenia (Beels, 2002; Bowen, 1959; Bowen, 1965). Furthermore, in the mid-1950's, a team of anthropologists and psychoanalysts, including Jay Haley, John Weakland, and Gregory Bateson, began to examine the communication patterns between the family members of individuals diagnosed with schizophrenia (Beels, 2002; Bateson, Jackson, Haley, & Weakland, 1956). Other pertinent factors leading to the growth of family therapy included the creation of the National Council on Family Relations in 1938, its associated journal that first appeared in

1939, and the creation of the American Association of Marriage and Family Counselors in 1942, which produced research examining the family functioning of individuals diagnosed with schizophrenia (Gladding, 2002; American Association of Marriage and Family Therapy, 2011; National Council on Family Relations, 2011). The goal of family therapy during this time period was to position “relationships at the center of understanding of human experience...The conceptual shift was from thinking of the family as the sum of individual psyches, to thinking of the family as a system made up of interrelated parts” (Flaskas, 2010, p. 238). For example, in his work, *The Psychodynamics of Family Life: Diagnosis and Treatment of Family Relationships*, Ackerman (1958) argued: “The family is the basic unit of growth and experience, fulfillment or failure. It is also the basic unit of illness and health” (p. 15). Ackerman recommended the treatment of the entire family given the assertion that symptoms are best understood within the context of the family system.

Possibly the most influential event that occurred in the 1940s was World War II. With death, grief, exposure to trauma, and families being separated for extended periods of time, mental health treatment focusing on the effects of war on families began to emerge (Gladding, 2002; Weinstein, 2004; Glass, 1954). After the war, stability became an important component in society, and loving homes and families were deemed essential to promoting cultural stability (Weinstein, 2004). Weinstein (2004) argued that “through their child-rearing practices, families, particularly mothers, stood as positive guardians of democracy, domestic security, and citizenship” (p. 24). This connection between families and society is evidenced by the writing during this time period. For instance, Ackerman and Jahoda (1950) argued that “cultural traditions and social forces do not exist as abstractions. Although they have been profitably

studied in isolation, they actually exist only in so far as they express themselves dynamically in the behavior of human beings” (p. 9; as cited in Weinstein, 2004, p. 32).

The period of the 1960s saw continued growth and expansion in the field of family therapy as the number of prominent professionals in the field grew, family therapy training programs expanded, and academic programs teaching family therapy techniques started and expanded (Gladding, 2002). For example, prominent therapists including Haley (1963) and Minuchin (Minuchin, Montalvo, Guerney, Rosman, & Shumer, 1967) began to publish articles on their work with families (Gladding, 2002). Additionally, training and academic programs, such as the Mental Research Institute (2011) in California expanded their services (Mental Research Institute, 2011; Gladding, 2002). Systems theory, which was originally introduced by Ludwig von Bertalanffy in the 1940s, was applied to families during this time period (Bertalanffy, 1950; Jaccard & Jacoby, 2010; Flaskas, 2010). A system can be defined as “an organized entity whose interrelated elements interact with one another so as to achieve some common goal” (Jaccard & Jacoby, 2010, p. 310). Systems theory focuses on processes and interrelated relationships among the individual elements within the system (Jaccard & Jacoby, 2010). Circular causality, or the “idea that causality in living systems is not a chain of ‘linear’ determining cause-and-effect dyadic interactions, but rather a constellation of multidetermining interactions, involving many parts of the system, occurring in a specific set of environmental conditions” was also applied to the family system during this time period (Flaskas, 2010, p. 238; Bateson, 1972).

1.2.2 The Expansion of Family Therapy

The time period between approximately 1969 through 1979 is often referred to as the second generation of family therapy, or the period of the “innovators and expanders” (Kaslow, 2000, p. 357). Several events marked the continued expansion of family therapy in the time period of the 1970s, including the continued increase in membership of the American Association of Marriage and Family Therapy as well as the start of the American Family Therapy Academy (Olson, Russell, & Sprenkle, 1980; American Family Therapy Academy, 2011; American Association of Marriage and Family Therapy, 2011).

Olson et al. (1980) argued that family therapy became a well-defined profession during this time period. Several advances in the field during the decade of the 1970s helped to shape the future of family therapy techniques as well as research on family therapy, including the creation of assessment tools used to guide interventions, the ability to statistically identify typologies or profiles of groups of individuals to guide theory development and treatment, and the creation of new treatment interventions including sex therapy and divorce therapy (Olson et al., 1980). With an increase in divorce rates and changes in the field of family therapy (e.g., the start of new theoretical perspectives), many in the field advocated for change in research and clinical practices (Bernardo, 1980). Some of these areas included a shift from descriptive to explanatory research, the need for cross-cultural validation of results and instruments, and the need to study areas of family life that had not yet been examined, including family development in older adults (Bernardo, 1980).

The trends and advancements in the field in the 1970s continued into the 1980s. The decade of the 1980s is often defined as the third generation of family therapy, or the period of the

“challengers, refiners and researchers” (Kaslow, 2000, p. 327) . A major trend that continued from the 1970s was the advancement of feminist theory (Kaslow, 2000; Gladding, 2002; Flaskas, 2010). Feminist theory became well defined by a group of family therapists who advocated for gender equality in therapeutic practices as well as society and openly discussed the relationship between sexism in society and the increased risk of experiencing mental health concerns (Gladding, 2002). Hare-Mustin (1978) was one of the early leaders of this theoretical movement. She argued that family therapy discriminated against women given that the practice generally accepted gender stereotypes (Hare-Mustin, 1978; Gladding, 2002). Other important advances in the field included the recognition of Post-Traumatic Stress Disorder based on research and work with veterans of Vietnam (Figley, 1985), the use of brief treatment interventions that focus on immediate problem resolution (de Shazer, 1985), the use of psychoeducation to promote education and awareness about mental health (Anderson, Reiss, & Hogarty, 1986), and the encouragement to alter treatment modalities based on societal needs including the continual increase in divorce rates (Sprenkle, 1985; Kaslow, 2000).

Social constructionism also became an important theory that was applied to family therapy and research in the 1980s (Gergen, 1985). Defined as the perspective that “holds that reality is a construction of the human mind” (Jaccard & Jacoby, 2010, p. 9), “tracking the relationship of social context to intimate experience” (Flaskas, 2010, p. 242) became an important therapeutic technique. Narrative treatment, which is a modality of treatment in which therapists attempt to understand their clients’ view or narrative of the world, also began during this time period (Flaskas, 2010; White & Epston, 1990).

Importantly, professional developments also continued throughout the 1980s including the publication of family therapy research in journals and the growth in the number of

publications including books on family therapy techniques and research (Gladding, 2002). For example, the International Association of Marriage and Family Counselors was created in 1986 (International Association of Marriage and Family Counselors, 2011; Gladding, 2002). Additionally, outcomes research focusing on the effectiveness of family therapy was widely published during this time period (Gurman, Kniskern, & Pinsof, 1986; Gladding, 2002).

1.2.3 Family Therapy from the 1990s to the Present

Known as the fourth generation of family therapy, or the period of the “integrators and seekers of new horizons” (Kaslow, 2000, p. 327), the period of family therapy from the 1990s to the present time has experienced an increase in the number of trained and licensed family therapists, academic and training programs, and new areas of treatment and theory (Gladding, 2002). Managed care companies have also impacted family therapy, as therapists are pressured to utilize solution focused modes of treatment that are brief in nature (Hoagwood et al., 1996; Kaslow, 2000; Hoyt, 1995). One example of a brief treatment approach is Berg and de Shazer’s (1993) solution focused therapy, which is a well-known brief treatment modality currently used in the field of family therapy (Berg, 1994; Kaslow, 2000). Solid research in the area of family therapy and assessment tools has also been important in the field in recent years (Kaslow, 2000). For instance, much research has been conducted on tools such as the Family Assessment Device (Epstein, Baldwin, & Bishop, 1983), and current journals, such as *Family Process*, publish articles that focus on the development of theory and research with families (Family Process, 2011; Kaslow, 2000).

Kaslow (2010) has recently labeled the last 10 to 15 years in the field of family therapy as the fifth generation as defined by the “researchers for an evidenced based reality” (Kaslow,

2010, p. 56). Research that expands beyond clinical experience is continuously promoted within the field as “pressure for having empirically validated and/or evidence based treatments...has mounted in the ranks of researchers, practitioners, third party insurers, and in academic and other training institutions and from certifying boards” (Kaslow, 2010, p. 59).

1.3 OUTPATIENT MENTAL HEALTH TREATMENT

There are five overarching goals or outcomes that have been established for children and families involved in mental health services. These goals are commonly examined in outcomes research, and they include:

(1) That children will be as free of psychopathology as possible; (2) that they function well at home, in school, and in the community; (3) that children and family members experience positive quality of life; (4) that children can benefit from a supportive environment in their families, at school, with peers, and in the neighborhood; and (5) that children experience as little of restrictive and coercive living situations (e.g., hospitals, detention centers) as possible (Burns, Hoagwood, & Mrazek, 1999, p. 199).

Outpatient treatment is the most common form of therapy offered to children and their families today and is estimated to be used by 5% to 10% of families in the United States (Burns et al., 1999). The use of outpatient treatment has also been extensively studied and is the focus of nearly 300 research studies (Burns et al., 1999). In examining nine meta-analysis studies determining the effectiveness of outpatient services for children, Burns et al. (1999) found that the likelihood of a decrease in the severity of symptoms was greater for those involved in outpatient services than for those without such treatment. The results from the nine meta-analyses found large effect sizes of outpatient treatment ranging between .7 and .8 (Burns et al.,

1999)¹. Classes of treatment were not found to consistently alter the effectiveness of the services, although some of the reviews showed favorable results for cognitive behavioral treatments (Burns et al., 1999).

In regards to outpatient treatment that specifically involves family therapy, Carr (2009) reviewed meta-analyses, systematic literature reviews, and reviews of controlled trials related to the effectiveness of family therapy services on the mental health of children and adolescents. Carr (2009) argued that:

The evidence supports the effectiveness of systematic interventions either alone or as part of multimodal programmes for sleep, feeding and attachment problems in infancy; child abuse and neglect; conduct problems (including childhood behavioral difficulties, ADHD, delinquency and drug abuse); emotional problems (including anxiety, depression, grief, bipolar disorder and suicidality); eating disorders (including anorexia, bulimia and obesity); and somatic problems (including enuresis, encopresis, recurrent abdominal pain, and poorly controlled asthma and diabetes; p. 3).

For example, in relation to anxiety, Carr (2009) found that family based treatments are more effective than individual treatments, especially in situations where parents are also diagnosed with an anxiety disorder. Family based treatments were also found to be more effective than individual treatment at improving family functioning (Carr, 2009).

Outpatient treatment, and specifically family therapy, has been found to be an effective mode of treatment when utilized with children, adolescents, and families when families are able to engage in and remain in services (Burns et al., 1999; Carr, 2009). Additionally, outpatient family therapy has evolved in communities to provide services for various needs and within diverse familial contexts (Gladding, 2002). Given that family therapy will continue to remain an option for families in need, researchers should continue to explore areas of outpatient treatment

¹ An effect size is a number ranging from 0 to 1 and is often used in research as “an overall measure of the magnitude of the effect” (Keppel & Wickens, 2004, p. 152).

with the intent of developing a better understanding of the families being served and how to better serve these families (Burns et al., 1999; Gladding, 2002).

1.4 SIGNIFICANCE AND DIRECTION OF RESEARCH WITH FAMILIES IN OUTPATIENT SETTINGS

Given the recent trend in the field toward family centered care and the family's inclusion in services, family focused research in outpatient treatment is necessary for developing an understanding of the families being served in outpatient clinics (American Academy of Pediatrics, 2003; Regan et al., 2006). Specifically, the classification of families based upon their level of family functioning as they initiate services from a community outpatient clinic is imperative information to gather and examine. This information can help researchers and clinical administrators gain a better understanding of the families being served and their level of functioning as they initiate treatment. The gathering of this information also has the potential of transforming and tailoring treatments to the families initiating services. With the increasing importance of managed care, outpatient clinical administrators are interested in finding ways to improve outcomes, while treating families using evidence based, yet cost effective modalities (Hoagwood et al., 1996; Kaslow, 2000).

Developing a typology of family functioning from those initiating services from a community based mental health clinic can help clinical administrators gain perspective on the families seen at the clinic in order to tailor practices. This typology would help to serve as an overarching conceptual model of family functioning within this setting. Comprising this typology would be specific clusters (i.e., "categories in which actual phenomenon...fit to a

greater or lesser extent;” Julnes, 2000, p. 543) that help to further explain the specific degree or level of functioning. Providing this descriptive knowledge would help to fill the gap in the literature (i.e., add to the outcomes based and longitudinal studies that are directed toward individual clinicians), help researchers and clinical administrators understand the level of functioning that families exhibit when they request outpatient services, and can potentially assist clinical administrators in tailoring, and thereby, improving the services they offer to families.

2.0 LITERATURE REVIEW

2.1 CHILD MENTAL HEALTH AND FAMILY FUNCTIONING

Family functioning is commonly defined in terms of the quality of the relationship between family members, including the degree to which family members feel close to one another and the level of conflict present between family members (Thompson et al., 2007). A multitude of studies have demonstrated that a child's experience of mental health symptoms, and a family's need for mental health services, are strongly related to the family's level of functioning. For instance, in examining the mental health needs of children in the child welfare system, Thompson et al. (2007) found that a chaotic family environment, defined by poor family functioning, poor social support, and parental psychological distress, strongly predicted the mental health needs of the child participants in the study. Furthermore, family environments with multiple stressors predicted greater need for child mental health services (Thompson et al., 2007).

Additionally, in examining data from the U.S. National Comorbidity Survey Replication, McLaughlin et al. (2009) utilized logistic regression and found that the experience of maladaptive childhood adversities, including parental mental illness, parental substance abuse, parental criminal behavior, family violence, physical abuse, sexual abuse, and neglect, predicted a severe mental health diagnosis in adulthood. The severity of the diagnosis indicated that the

symptoms of the disorder were so severe that they disrupted the individual's ability to function on a daily basis (e.g., go to work, interact with friends and family, be void of suicidal or homicidal thoughts; McLaughlin et al., 2009). Moreover, severity of the mental health illness in the adult participants increased as the number of childhood adversity risk factors experienced also increased (McLaughlin et al., 2009). The researchers found that early exposure to childhood adversities greatly increased the likelihood of experiencing anxiety, stating that "early adverse experiences may create a cognitive predisposition to perceive events as outside an individual's control, generating a lasting psychological vulnerability to the development of anxiety" (McLaughlin et al., 2009, p. 856). Thus, the experience of childhood adversities as they relate to the functioning of the family has been found to predict mental health concerns in children, including long lasting effects that persist throughout adulthood. Given these results, it is evident that examining family functioning is essential to gaining more knowledge about the families being served so that appropriate services can be offered.

2.2 MCMASTER MODEL OF FAMILY FUNCTIONING

The McMaster Model of family functioning is based upon a systems theory of family therapy (Epstein et al., 1983). "In systems theory, a system is a set of elements standing in interaction with one another. Each element in the system is affected by whatever happens to any other element" (Gladding, 2002, p. 68). Thus, by viewing the family as a system, linear causality, or the belief that one cause leads to one effect, is replaced with circular causality, or the belief that events are interrelated (Gladding, 2002; Flaskas, 2010).

The McMaster Model of family functioning includes several important underlying assumptions:

- 1) All parts of the family are interrelated.
- 2) One part of the family cannot be understood in isolation from the rest of the family system.
- 3) Family functioning cannot be fully understood by simply understanding each of the individual family members or subgroups.
- 4) A family's structure and organization are important factors that strongly influence and determine the behavior of family members.
- 5) The transactional patterns of the family system strongly shape the behavior of family members (Miller, Ryan, Keitner, Bishop, & Epstein, 2000, p. 169).

Additionally, the McMaster Model of family functioning identifies six aspects of family interactions and relationships that are essential in measuring and assessing the level of functioning of the family system. These six areas include communication, problem solving, roles, affective responsiveness, affective involvement, and behavior control (Miller et al., 2000). Each of these six areas is related to both the functioning of the family system and the individual family members (Miller et al., 2000).

Given the importance of these six individual aspects on family functioning as a whole, the following literature review will include important findings within these six areas. The Family Assessment Device (Epstein et al., 1983) will also be used as an instrument for the present study in order to assess family functioning.

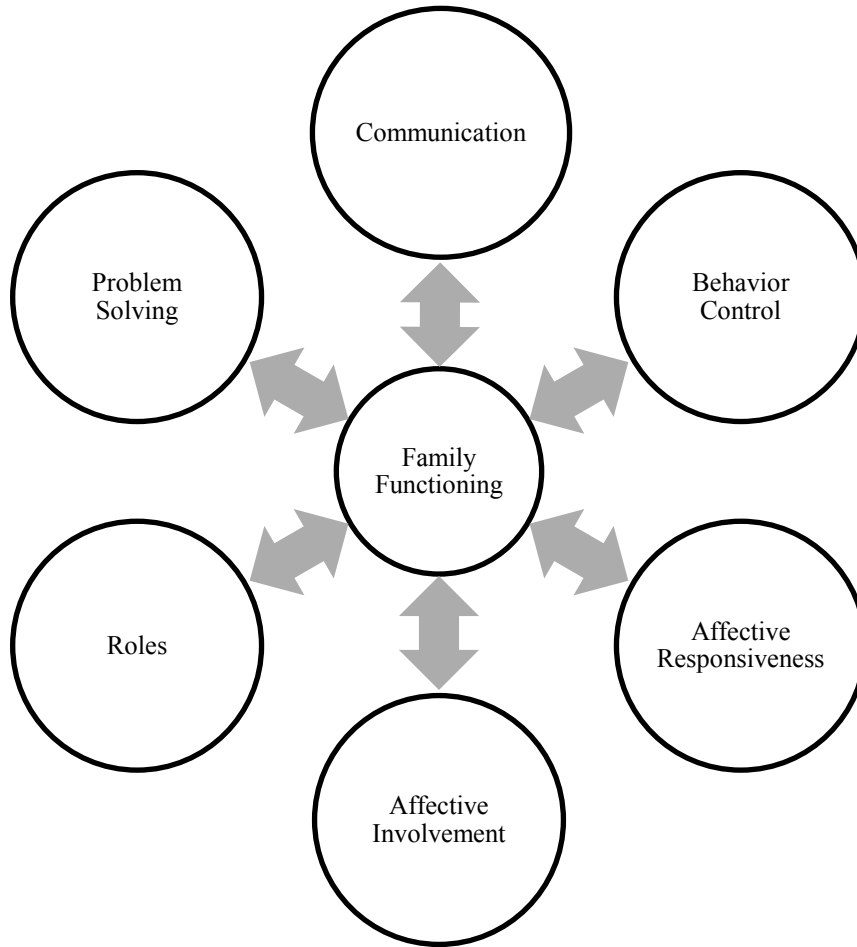


Figure 3. McMaster Model of Family Functioning (Miller et al., 2000).

2.2.1 Communication

Family communication is defined as “how information is exchanged within a family” (Miller et al., 2000, p. 170). Specifically, positive communication has been defined as “sending clear and congruent messages, expressing empathy, providing supportive comments, and demonstrating effective problem solving skills” (Smith, Freeman, & Zabriskie, 2009, p. 79). Communication is often used to help families organize their actions into predictable forms of behavior (Clark & Shields, 1997). Several important considerations in assessing the quality of communication

among family members include whether the information is directed at the family member for whom the information is intended, whether the information is well-defined instead of vague, and whether the important information is communicated directly to the intended individual as opposed to hidden within other messages (Miller et al., 2000). Individuals often learn how to cope with and appropriately handle interpersonal conflict within their original family setting (Koerner & Fitzpatrick, 1997). Basic communication skills are modeled by family members, and the importance of these skills continues throughout adulthood (Koerner & Fitzpatrick, 1997). Thus, given the importance of communication in family settings, studying communication as an area of family functioning is imperative.

Communication has been linked with overall family functioning and child outcomes in a multitude of studies. For example, positive family communication has been linked to lower rates of adolescent delinquency such as theft and truancy (Clark & Shields, 1997) as well as lessened negative effects of violent television viewing on children (Kramer, 1998). Alternatively, poor family communication has been found to be correlated with communication apprehension (Hsu, 1998), communication avoidance (Avtgis, 1999), and reticence (Kelly et al., 2002).

Family communication has been found to be significantly related to family functioning. Specifically, communication has been related to the family's cohesion, or "how family members balance the importance of independence with the mutuality of being a member of a family system" (Smith et al., 2009, p. 80), and the family's flexibility, or "how family systems balance stability versus change" (Smith et al., 2009, p. 80). In path analyses, family communication has been found to mediate the relationship between family leisure activities and family functioning (Smith et al., 2009). "The path analysis suggests that from a youth perspective, core family leisure activities had a direct influence on family cohesion and indirectly influenced family

flexibility through family communication” (Smith et al., 2009, p. 86). In fact, parents in the study reported that a primary reason they provide and engage in family leisure and recreation activities is for increased positive communication among family members. This increased positive family communication was found to influence the functioning of the family system and individual family members (Smith et al., 2009).

Schrodt (2005) further examined this relationship of family communication, by asking 426 young adults about their views on their families’ communication patterns, as well as their families’ functioning. In the study, structural traditionalism was defined as the extent to which families meet expectations, including role expectations that are set by external authority figures, such as expectations created by society (Schrodt, 2005). Conflict avoidance was defined as the family’s decision to suppress conflict or disagreement versus choosing to openly express differences in opinions (Schrodt, 2005). Schrodt (2005) found that family expressiveness was positively related to family functioning, while structural traditionalism and conflict avoidance were found to be negatively correlated with family functioning (Schrodt, 2005). Schrodt (2005) argued that the participants who “perceive that their family members believe in the free and open exchange of thoughts and feelings, and at the same time believe in addressing...unpleasant topics and points of contention, are more likely to perceive stronger emotional bonds” (pp. 370-371). In regards to rituals, or “a symbolic form of communication that is enacted systematically and repeatedly over time and which holds special meaning for family members” (Baxter & Clark, 1996, p. 254), the family’s ability and commitment to ritualize have been found to be related to positive and supportive family communication. Families who engage in rituals have been found to experience high levels of emotional bonding and highly supportive relationships, as rituals

help family members achieve a sense of family identity and celebrate the family's heritage and traditions (Baxter & Clark, 1996).

Family communication has also been correlated with an individual's personality characteristics. In questioning 196 young adults, Huang (1999) found that family communication patterns were linked to six personality traits including self-monitoring (ability to monitor behavior to meet social requirements), social desirability (the way in which an individual expresses oneself in public to maintain social approval), desirability of control (traits such as assertiveness and decisiveness), self-esteem (one's self-judgment or evaluation of self-worth), self-disclosure (extent to which one shares personal information with others), and shyness (level of discomfort when spending time with strangers or acquaintances). Huang (1999) utilized Ritchie and Fitzpatrick's (1990) family communication pattern theory that categorizes families into two categories including conformity oriented, which includes families that support parental authority and child conformity to this authority, and conversation oriented, which is characterized by families who support open communication including discussions that incorporate disagreement. The researcher found that being a part of a family that was conversation oriented was positively related to self-disclosure, desirability of control, self-esteem, and sociability (Huang, 1999). Shyness was negatively correlated with being a part of a family described as conversation oriented (Huang, 1999). However, being in a family described as conformity oriented was positively related to shyness and self-monitoring, while negatively correlated with self-esteem and sociability (Huang, 1999). Thus, Huang (1999) found a significant relationship between family communication patterns experienced as a child and adult personality characteristics.

In relation to communication and child outcomes, Engels, Finenauer, and van Kooten (2006) studied the relationship between patterns of lying between adolescents and their parents. This topic is of great importance in relation to family functioning as lying and deceit are directly related to the trust found in family relationships (Engels et al., 2006). Engels et al. (2006) studied 671 pairs of parents and adolescents and administered both parental and adolescent surveys to gauge lying behavior, emotional functioning, behavioral functioning, and family functioning. The researchers found “that children who frequently lie to their parents show less disclosure, higher levels of secrecy, poorer communication patterns, less trust between the parents and their child and more alienation” (Engels et al., 2006, p. 956). Moreover, lying was also positively related to behavioral and emotional concerns such as aggressive behaviors, delinquency, and rates of depression (Engels et al., 2006). Thus, problems in communication between parents and children have been found to be related to both the building of trusting family relationships as well as child mental health outcomes.

Aspects of family communication have also been linked to child mental health concerns, including the risk of suicide, which has been found to be related to the need for and request of mental health services (Greenham & Bisnaire, 2008). Riesch, Jacobson, Sawdey, Anderson, and Henriques (2008) examined parent-child communication as a potential factor in elementary school aged children’s (ages 9 to 12) risk of attempting suicide. Children from 179 elementary schools in two cities completed the researchers’ survey. Riesch et al. (2008) defined parent-child communication as “the ability to share thoughts and feelings, approach difficult topics and ask for help” (p. 266). The researchers found that the children in the study who reported having thoughts of killing themselves also tended to report “less cohesion, less open communication, less supervision, and less family caring” (Riesch et al., 2008, p. 272) than children who denied

having thoughts about harming themselves. Furthermore, higher levels of parent-child conflict were found to be related to higher rates of inpatient rehospitalization rates (Riesch et al., 2008). Similarly, Kwok and Shek (2010) examined correlates of suicidal ideation in Chinese adolescents. The researchers utilized a cross-sectional survey with 42 schools in the Hong Kong area, studying emotional competence, social problem solving skills, hopelessness, suicidal ideation, parent-adolescent communication, and family functioning (Kwok & Shek, 2010). The results of both correlation and regression analyses suggested that lower parent-adolescent communication was significantly related to an increase in suicidal ideation among adolescents. Hopelessness was the highest predictor of suicidal ideation, while mother-adolescent communication and family functioning followed (Kwok & Shek, 2010). Kwok and Shek (2010) argued that their results support the McMaster Model of family functioning in that “parent-child communication and family functioning are determinants of adolescent quality of life (i.e., suicidal ideation)” (p. 414).

Understanding communication is essential to understanding the functioning of the family system as well as the individual family members. Communication has been linked to overall family outcomes including cohesion and flexibility (Schrodt, 2005; Smith et al., 2009) as well as individual child outcomes both in childhood (Engels et al., 2006; Kwok & Shek, 2010; Riesch et al., 2008) and later in life (Huang, 1999). When a parent initiates a referral or follows through on the recommendation for family therapy or mental health services for their child, communication should be assessed given the relationship found in the research between communication and family, as well as individual, functioning.

2.2.2 Problem Solving

Problem solving can be defined as the ability to “resolve problems at a level that maintains effective family functioning. A family problem is seen as an issue for which the family has trouble finding a solution, and the presence of which threatens the integrity...of the family” (Miller et al., 2000, p. 170). Problems can be defined as either instrumental, such as financial management, or affective, such as the emotional experiences of the family members (Miller et al., 2000).

Often, the experience of seeking mental health services requires the family’s use of problem solving skills. For example, “families may experience stress as crises arise that are often found with children with serious emotional disturbances, such as dealing with emergency services, interactions with the police, involuntary commitment, and finding services for their child” (Geller & Biebel, 2006, p. 278). In fact, a recent qualitative study utilized grounded theory, or “the approach of letting theory emerge from data rather than using data to test theory” (Jaccard & Jacoby, 2010, p. 256), to study families’ experiences with hospitalizing their children (Scharer & Jones, 2004). Scharer and Jones (2004) found that in their interviews with parents of children receiving services in a psychiatric inpatient facility, the parents often called the hospital “the last resort” (p. 79) and the decision to hospitalize as particularly stressful. The experience of seeking mental health services can be a stressful event, and when combined with other co-occurring family stressors, can influence the family’s abilities to effectively solve problems. How families cope with and solve these life stressors is a pertinent factor in family functioning.

Parenting strategies can also be viewed as a type of problem solving approach as parents discipline children based upon a problem behavior of concern. The discipline is the parent’s

attempt to end the concerning behavior. In a study examining rates of psychiatric rehospitalization, Blader (2004) found that use of corporal punishment was highly correlated with an increased risk of rehospitalization. Blader (2004) argued that “among contextual influences, family factors seem particularly important to children’s readmission...parental stress, parenting practices, and family environment constituted a group of family-related predictors” (p. 441). Thus, in Blader’s (2004) sample, parents’ use of corporal punishment as a problem solving technique had a direct relationship to the child’s mental health symptoms and need for services.

Problem solving skills, and specifically interpersonal or social problems solving skills, have been found to be related to the family environment and functioning in a number of studies. Kennedy, Felner, Cauce, and Primavera (1988) defined interpersonal cognitive problem solving skills as a “constellation of skills that includes the ability to identify problems, the capacity to generate alternative solutions to problems, and the ability to specify a viable course of action after evaluating the consequences of the possible alternative courses of action” (Kennedy et al., 1988, p. 74). One hundred and seventy-five students selected randomly from three Northeastern city high schools were interviewed and given multiple surveys studying moral judgment, problem solving abilities, family functioning, and self-ratings including school performance (Kennedy et al., 1988). The majority of participants were from families who experienced low socioeconomic status and were minorities (Kennedy et al., 1988). The researchers found that the participants who rated their families high on “personal growth and development (e.g., independence, intellectual orientation), and system maintenance (e.g., order and organization)” (Kennedy et al., 1988, p. 77) on the Family Environment Scale had significantly better scores on measures of interpersonal cognitive problem solving skills. Therefore, the family environment or

functioning of the family system was directly related to the participants' abilities to solve problems in social and interpersonal situations (Kennedy et al., 1988).

Siu and Shek (2010) recently expanded the definition of social problem solving skills to include not only problem identification and recognition of appropriate solutions, but also “a positive orientation toward problem solving (problem orientation) and the management of behavioral styles like impulsiveness and acting out behavior, or procrastination and avoidance” (p. 394). The authors argued that social problem solving skills lead to a better quality of life due to enhanced interpersonal relationships, thus making problem solving skills an important component of individual and family functioning (Siu & Shek, 2010). Siu and Shek (2010) studied 1,462 students, ages 11 through 17 years, to examine the relationship between social problem solving skills and family functioning. The researchers found that the problem solving skills of parents were significantly more important than the child's skills in predicting parent-child conflict (Siu & Shek, 2010). This finding could possibly be explained by the fact that parents are generally more experienced in problem solving skills than their children, and they also are in a position to use and model these skills when in conflict with their children (Siu & Shek, 2010). Therefore, parents can have a large impact on the experience of conflict in the family setting “and are the key determinant of the quality of the relationship in parent-child relationships” (Siu & Shek, 2010, p. 403). Siu and Shek (2010) also found that the children who scored higher on measures of positive problem solving skills and approaches were also significantly less likely to experience depression and anxiety. This research thereby supports the relationship between family functioning and problem solving skills, which in turn, can influence the mental health needs of children and families.

In examining the effects of family functioning on the experience of children in school, specifically in regards to the experience of bullying, Stevens, De Bourdeaudhuij, and Van Oost (2002) examined family functioning and problem solving skills in families of 1,719 fifth and sixth grade students across 28 schools. Bullying behaviors, victimization, family functioning, parenting practices, and family problem solving skills were all assessed from reports from both children and parents (Stevens et al., 2002). Children who classified themselves as being bullies reported “less cohesion, expressiveness, organization, control, and social orientation, and more family conflict within the family” (Stevens et al., 2002, p. 423) . Overall, these results suggest that the family environment and functioning are directly related to both the child’s problem solving skills and his or her experience of bullying in school. Similarly, in relation to mental health concerns, Ghanizadeh and Shams (2007) studied differences in family functioning in Iran, comparing 49 families with a child diagnosed with attention-deficit/hyperactivity disorder (ADHD) to 51 families where no child had been diagnosed with ADHD. The researchers matched the families in regards to “age, sex, educational level, family income, level of parental education, ethnicity, and residential area” (Ghanizadeh & Shams, 2007, p. 1). Using the Family Assessment Device, the researchers found that parents of children diagnosed with ADHD were more reactive and negative in their parenting strategies (Ghanizadeh & Shams, 2007). Such parenting behavior was positively related to the reports of children diagnosed with ADHD, who indicated feeling unable to talk with their parents about their problems (Ghanizadeh & Shams, 2007). Given these results regarding problem solving skills, Ghanizadeh and Shams argued that more parents should engage in parent management training, in order to learn parenting strategies and problem solving skills to use with children diagnosed with ADHD. Ghanizadeh and Shams

(2007) suggested that this type of training would help families to learn alternative problem solving strategies and to model appropriate skills regarding problem solving.

Additionally, Gorman-Smith, Tolan, and Henry (2000) studied family functioning, and specifically, parenting practices in relation to adolescent delinquent behavior. One thousand one hundred and five males between the fifth and seventh grades were recruited from 17 Chicago public schools for this longitudinal study which lasted for four years (Gorman-Smith et al., 2000). Gorman-Smith et al. (2000) found that the families who were having the most difficulty in parenting practices, discipline, and/or emotional bonding between the family members, had children who were most at risk for delinquent behavior. The researchers argued that “this set of results suggest that prevention programs need to emphasize multiple aspects of family functioning to maximize impact” (Gorman-Smith et al., 2000, p. 192). Similarly, in a recent attempt to promote family preservation, in-home family supportive services have been created and used to help families improve functioning and develop problem solving skills and strategies, while protecting the welfare of the children inside the home (Fernandez, 2004). Fernandez (2004) examined the relationship between these in-home supportive services and changes in family functioning over a six month time period, with families in Australia, using both qualitative and quantitative methods. Additionally, a multi-informant method was used in which parents, children and caseworkers were asked to complete various surveys, as well as semi-structured interviews (Fernandez, 2004). Families were referred to the study for several reasons including child maltreatment, intimate partner violence, and the need for assistance regarding the management of troublesome child behaviors (Fernandez, 2004). Fernandez (2004) found that after six months of experiencing in-home family supportive services, child anxiety symptoms declined, child quality of life improved, and externalizing behaviors such as hyperactivity and

aggression decreased. Significant changes and improvements in the parent's ability to handle the child's behaviors and utilize appropriate problem solving skills in enacting discipline were also found (Fernandez, 2004). In the qualitative findings, several parents discussed the benefits of their improved problem solving capabilities. One parent remarked, "they have taught us how to live with each other and just how to cope with all of the little things that come up in everyday life" (Fernandez, 2004, p. 101). Fernandez (2004) argued that parental distress greatly impacted the parents' abilities to effectively solve problems, which in turn influenced the behavior and response of the children as well as the parent-child emotional bond and relationship.

Problem solving skills have been linked to family functioning, specifically, interpersonal skills (Kennedy et al., 1988; Siu & Shek , 2010), mental health concerns (Siu & Shek, 2010; Ghanizadeh & Shams, 2007; Fernandez, 2004), bullying behaviors (Stevens et al., 2002), delinquent behavior (Gorman-Smith et al., 2000), and parenting practices (Blader, 2004; Gorman-Smith et al., 2000; Fernandez, 2004). Given that problem solving capabilities have been related to a number of various areas regarding family and individual functioning, assessing problem solving skills in an effort to understand the functioning of a family system is pertinent. Problem solving skills underlie the family's basic ability to appropriately handle and resolve conflict, which is a skill that children learn and apply in adulthood (Koerner & Fitzpatrick, 1997).

2.2.3 Roles

Roles can be defined as the "recurrent patterns of behavior by which individuals fulfill family functions" (Miller et al., 2000, p. 171) . There are many ways in which roles influence the functioning of the family. For instance, a grandmother may have to assume the role of parent

when her grandchildren are removed from their home and placed with her in a kinship arrangement. Alternatively, a child living in a household with one parent may have to assume the responsibility for parental tasks to help maintain the level of functioning at which the family is currently operating. Regardless of the setting, roles are an essential part of a family's functioning. Specific roles in families are determined by a number of factors including age, culture, religion, and family tradition (Gladding, 2002). However, "roles in healthy families are clear, appropriate, suitably allocated, mutually agreed on, integrated, and enacted" (Gladding, 2002, p. 37).

Concerns regarding familial roles can often be seen in family settings of individuals diagnosed with borderline personality disorder, as individuals with this diagnosis have been described as having difficulty forming a secure self-concept, and difficulty integrating opposing feelings, such as love and hate (Kirsten, van Lelleveld, & Venter, 2006). Kirsten et al. (2006) examined a group of individuals diagnosed with borderline personality disorder in South Africa, in an ethnographic and multiple case study design using grounded theory. Using the McMaster Model of family functioning, the researchers identified several concerns regarding familial roles (Kirsten et al., 2006). Kirsten et al. (2006) found "deficient patterns of behavior that prevent normal family functions and the fulfillment of emotional and other needs" (p. 330), including inadequate nurture and support, as well as rigid and reversed roles. In relation to nurture and support, the participants described familial interactions that were extreme, including either no support or an excessive amount of support (Kirsten et al., 2006). For instance, one participant reported that her mother never showed any signs of physical affection, such as hugs and kisses, but that her father constantly provided displays of affection (Kirsten et al., 2006). The participant reported that she received too much affection from one parent and not enough from the other

parent (Kirsten et al., 2006). Rigid roles were also found to be of significant importance in the study and were denoted as unchanging and inflexible labels given to family members (e.g., “scapegoat,” “normal one;” Kirsten et al., 2006, p. 331). Additionally, role reversal, including family members being placed into alternative roles or positions (e.g., a child assuming parental responsibilities) was also found to be a significant theme throughout the findings (Kirsten et al., 2006). Overall, the researchers discovered that roles can be related to the functioning of the family system as well as to the mental health of the individual family members (Kirsten et al., 2006).

Similar findings regarding the importance of roles have been found in other fields of study as well. McNamara and Loveman (1990) examined differences in family functioning among female participants diagnosed with bulimia, individuals who were at risk for developing an eating disorder, and individuals not at risk for developing an eating disorder. The researchers found that individuals diagnosed with bulimia “may not have learned appropriate impulse control or boundary setting in their families of origin due to the chaotic atmosphere within their families” (p. 522). As in Kirsten et al.’s (2006) study regarding individuals diagnosed with borderline personality disorder, family settings that offer poor boundaries and roles may be related to an individual’s experience of mental health concerns and inability to effectively utilize problem solving skills. Alternatively, Dimitropoulos, Klopfer, Lazar, & Schacter (2009) looked at the influence of a diagnosis of anorexia nervosa on siblings not diagnosed with the disorder. In a qualitative study using semi-structured interviews, the researchers found that the roles of the siblings were significantly impacted by the disorder’s influence on the family. All siblings in the study reported that they felt as though their main familial role became one of mediator and protector of the sibling; “a consistent theme in the stories of siblings was that they became

involved in supporting, protecting, and mediating conflict within the family” (Dimitropoulos et al., 2009, p. 354). The sibling participants also suggested a family approach to dealing with the disorder, one that focuses on the influence of the family, and which is not intended to blame any individual family member (Dimitropoulos et al., 2009). Interestingly, when examining family roles through the eyes of someone with a diagnosis, or the sibling of an individual with a diagnosis, the roles of the family members are found to be an important aspect of coping with the disorder throughout the process of treatment.

In working with adolescents who experienced substance abuse concerns, Sim and Wong (2008) also found that roles played a significant part in family therapy. Structural family therapy was used throughout the sessions, which helped the therapists to focus on the boundaries and roles of the family members (Sim & Wong, 2008; Gladding, 2002). Sim and Wong (2008) found that two of the five content themes revolved around poor boundaries and insufficiently defined familial roles. For example, the mother of one family participating in treatment was described as often displaying enabling behaviors, while the father expected the adolescent to immediately stop using substances (Sim & Wong, 2008). Without a clear understanding of parental roles and differing expectations, the adolescent expressed confusion about his goals in treatment (Sim & Wong, 2008). Similarly, given the substance abuse, both parents expressed confusion and frustration over how best to help their son (Sim & Wong, 2008).

Familial roles encompass a number of different tasks from who takes the garbage out on a weekly basis to who becomes the scapegoat in family conflict. Examining the roles of individual family members when they are initiating treatment is important in building interventions that are intended to meet families at their level of functioning.

2.2.4 Affective Responsiveness and Involvement

Affective responsiveness “is defined as the ability of the family to respond to a range of stimuli with the appropriate quality and quantity of feelings” (Miller et al., 2000, p. 171) . Affective involvement refers to the “degree to which the family as a whole shows interest in and values the activities and interests of individual family members” (Miller et al., 2000, pp. 171 -172). This aspect of family functioning describes the ways in which family members show appropriate interest in others, while maintaining appropriate distance to allow for independence (Miller, 2000). Having the ability to appropriately regulate emotions is also an important aspect of both affective involvement and responsiveness.

In Ghanizadeh and Shams’ (2007) study examining differences in family functioning between children diagnosed with ADHD and those not diagnosed, the researchers found important differences in affective responsiveness and involvement. Specifically, families with children diagnosed with ADHD reported experiencing difficulties in these areas, leading to more reactive and negative emotional displays (Ghanizadeh & Shams, 2007). Additionally, in their study of the differences in family functioning in individuals diagnosed with bulimia, individuals at risk for developing an eating disorder, and those not at risk for developing an eating disorder, McNanama and Loveman (1990) found that individuals diagnosed with bulimia “do not learn effective verbal methods for expressing negative emotion and labeling problems and do not have the confidence that satisfactory problem solving will occur if problems are discussed” (p. 522). Thus, the ability to label emotions, appropriately express emotions, and regulate emotions are pertinent factors in the study of family functioning and child mental health needs.

Affective responsiveness and involvement have been related to family member's mental health concerns in a multitude of studies. For example, "parent's depressive symptoms are associated with multiple differences in interaction patterns, including increased angry and depressive marital conflict tactics, verbal hostility, defensiveness, withdrawal, and insults, as well as more negative displays of anger and sadness" (Du Rocher Schudlich, Youngstrom, Calbrese, & Findling, 2008, p. 2). These affective experiences also decrease positive problem solving skills and positive communication patterns in families (Du Rocher Schudlich et al., 2008). Therefore, parental mood disorders have been related to poorer child outcomes in relation to the use of coping skills and the management of stress, as well as the ability to handle stressful circumstances and environments (Du Rocher Schudlich et al., 2008). In a study of children between the ages of 5 and 17 years, Du Rocher Schuldlich et al. (2008) found that having a parent diagnosed with a mood disorder was significantly related to impaired family functioning. Specifically, unipolar depression was negatively related to problem solving capabilities (Du Rocher Schudlich et al., 2008). Overall, the researchers found an indirect path between parental diagnosis of depression or bipolar disorder and family conflict, mediated by family functioning (Du Rocher Schuldlich et al., 2008). Additionally, family conflict was found to be positively correlated with rates of childhood diagnosis of bipolar disorder (Du Rocher Schuldlich et al., 2008).

Often, families seek mental health services for their children when there is a family crisis, such as the experience of a family member being diagnosed with a medical disease. Lindqvist, Schmitt, Santalahti, Romer, and Piha (2007) examined differences in family functioning between adolescents who were between the ages 11 and 17 years and had experienced a parent being diagnosed with cancer and a control group of adolescents who did not have a parent with a

diagnosis of cancer. All of the adolescents who had a parent diagnosed with cancer participated in the study within 4 to 12 months of learning of the diagnosis, and all participants completed a number of questionnaires including the Family Assessment Device (Lindqvist et al., 2007). Using stepwise regression analyses, Lindqvist et al. (2007) found that communication, affective involvement, and problem solving skills were the most predictive of healthy family and individual functioning. Specifically, appropriate affective involvement was significantly related to a decrease in adolescent externalizing behaviors such as truancy or aggression (Lindqvist et al., 2007). Additionally, positive communication and appropriate affective involvement were predictive of healthy family and individual functioning for the control group as well, suggesting that these components of family health are essential for all families in order to maintain positive functioning (Lindqvist et al., 2007).

Similarly, expression of anger is thought to be affected by the family environment and the functioning of the family. Researchers have found strong correlations between parental anger directed toward children, as well as poor parental self-regulation, and later violent behaviors committed by those children (Avci & Güçray, 2010). Comparing adolescents who experienced punishment from their school or local police department due to a violent crime with adolescents who did not have a history of committing violent crimes, Avci and Güçray (2010) found that there were distinct familial differences between the groups of adolescents as indicated by multiple measures, including the Family Assessment Device. The researchers found that participants who had a history of violent crimes also experienced higher levels of expressed anger and aggression, when compared to the adolescents who did not have a history of violent acts (Avci & Güçray, 2010). Alternatively, the researchers found that for the adolescents who had a history of violent acts, internalized anger was related to the adolescents' experience of

depression and somatic complaints (Avci & Güçray, 2010). Adolescents who act out violently often have experienced family members with psychological concerns, aggressive acts, and alcohol use, all of which can influence the expression and regulation of emotions in the home (Avci & Güçray, 2010). Based on the results, Avci and Güçray (2010) argued for family centered treatment options that involve teaching family members appropriate coping skills for regulating and expressing anger, including problem solving and communication skills.

Duane, Carr, Cherry, McGrath, and O'Shea (2003) studied adolescent males who had sexually mistreated other children. The study included 22 adolescent males engaged in a treatment program for individuals who have sexually offended others and 10 adolescent males engaged in mental health outpatient services who did not have a history of sexually acting out behaviors (Duane et al., 2003). Nineteen adolescent males, matched to the adolescents in the treatment program who did not have the experience of mental health services or a history of sexually acting out behaviors, were also included in the study (Duane et al., 2003). After collecting data from both children and parents, including the use of the Family Assessment Device, Duane et al. (2003) found that the adolescent males who had a history of sexually acting out experienced child abuse themselves with emotional abuse being the predominant form of maltreatment, 18% had been placed outside of the home given family difficulties including history of abuse, and a significant proportion also witnessed their parents using substances in the home. Duane et al. (2003) found that those with a history of sexually acting out behaviors had significantly more internalizing behaviors, and had experienced a significant amount of emotional turbulence in the family setting, as evidenced by the significant differences on the Family Assessment Device regarding affective involvement and responsiveness. The researchers argued for family involvement in treatment in order to disrupt family patterns and behaviors that

may indirectly support the sexually acting out behaviors, while also building upon family strengths and resources as protective factors for adolescents.

Affective involvement and responsiveness are important family concepts to consider when assessing for family functioning. Affective components have been found to be related to family functioning in various child and adolescent mental health diagnoses (Ghanizadeh & Shams, 2007; McNamara & Loveman, 1990), the experience of having a parent with a mental health (Du Rocher Schuldlich et al., 2008) and medical diagnosis (Lindqvist et al., 2007), as well as the expression of anger and aggression within the family setting (Avci & Güçray, 2010; Duane et al., 2003). The ability to correctly identify emotions, regulate emotions, show interest in others while maintaining adequate space for independence, and appropriately handle conflict are all important concepts children learn and apply in adulthood (Koerner & Fitzpatrick, 1997; Miller et al., 2000). Given these findings, it is evident that the ability to cope with emotions is a pertinent skill that is related with healthy individual and family functioning.

2.2.5 Behavior Control

As theoretically outlined by Miller et al. (2000), behavior control refers to the behavior of family members in three situations including dangerous situations (e.g., the family closely monitors the members for safety purposes), situations in which psychobiological needs are expressed (e.g., eating meals, appropriately handling aggression), and situations that involve interpersonal and social behaviors (e.g., gatherings with individuals outside of the immediate family).

Several studies have examined the relationship between behavior control and mental health needs of children. For example, in Kirsten et al.'s (2006) ethnographic research of individuals diagnosed with borderline personality disorder, the researchers found that parents of

individuals with borderline personality disorders often display contradictory methods of parenting and controlling behavior. The researchers found that participants often described one parent as being very rigid and strict, while the other parent rarely set limits (Kirsten et al., 2006). Additionally, McNamara and Loveman (1990) studied differences in family functioning between individuals diagnosed with bulimia and those at risk for developing an eating disorder. The researchers found that individuals diagnosed with an eating disorder, as compared to control subjects, often experienced “chaotic” (Kirsten et al., 2006, p. 522) home environments with limited structure. Furthermore, in their study comparing adolescents with a history of violent crimes versus adolescents without this history, Avci and Güçray (2010) found that exposure to parents’ aggressive and abusive behaviors is related to violent acts committed by adolescents.

Behavioral control has been also related to child mental health concerns, specifically anxiety disorders. Hughes, Hedtke, and Kendall (2008) used the Family Assessment Device with 178 children who were diagnosed with a primary anxiety disorder and 52 children who did not meet criteria for a mental health diagnosis. Mothers, fathers, children, and clinicians were all asked to complete a number of questionnaires, and multiple regression analyses were utilized to determine the degree to which parental and child mood symptoms predicted family functioning. Mothers and fathers who had a child diagnosed with an anxiety disorder reported poorer family functioning in general, and they specifically reported concerns with behavioral control. Strict behavioral rules, inflexible to change based on developmental needs and expectations, were commonly found among parents of children experiencing anxiety. Given the parent’s attempt to control the environment, most likely in an attempt to shelter the child from additional anxiety, the children were found to lack appropriate skills to effectively and independently cope with the experience of anxiety (Hughes et al., 2008).

Similarly, Vickers (1994) examined the relationship between family cohesion, family adaptability, and the risk of dropping out of school. Vickers (1994) divided the 104 elementary school participants into those at risk for dropping out of school versus students who did not experience any risk factors. The risk factors included grade retention, excessive absences, achievement scores, and nominations by school principals, teachers, and nurses (Vickers, 1994). Vickers (1994) referred to cohesion as “how family members balance the importance of independence with the mutuality of being a member of a family system” (Smith et al., 2009, p. 80), while flexibility referred to “how family systems balance stability versus change” (Smith et al., 2009, p. 80). After performing analyses of variance, Vickers (1994) found that children who were determined to be at risk of dropping out of school were significantly more likely to be in family settings described as significantly less cohesive and less flexible regarding rules and structure. Vickers (1994) suggested that “low scores on the adaptability scale (rigid) may reflect a family’s difficulty with negotiation skills and flexible communication. Difficulty with power issues and overresponsible or overdependent behavior patterns are also common” (p. 268).

Family functioning, and specifically the flexibility of rules and behavior, has also been found to be related to adolescent addictive behaviors. Tafà and Baiocco (2009) asked 252 families, including adolescents and parents, to complete a number of questionnaires including measures of family functioning. The mean age of the adolescent participants was 17.59 years (Tafà & Baiocco, 2009). Stepwise regression analyses were completed with family functioning listed as the predictor variable for adolescent addictive behaviors, including addictions to substances, food, sex, internet, computers, gambling, shopping, working, exercise, and relationships (Tafà & Baiocco, 2009). The researchers found that family functioning

significantly predicted adolescent addictive behaviors (Tafà & Baiocco, 2009). Tafà & Baiocco (2009) stated:

Data provide support for the proposal that family system characteristics could predict adolescent addictive behavior...adolescent addictions increase in families characterized by weak emotional bonds (low cohesion) and the incapacity to change their power structure, role relationships, and relationship rules in response to situation and developmental stress (high adaptability; p. 388).

Behavior control, including areas such as rules, adaptability of structure, and consequences to behaviors, has been correlated with mental health concerns (Kirsten et al., 2006; McNamara & Loveman, 1990; Hughes et al., 2008), acts of aggression and violence (Avci & Güçray, 2010), risk of dropping out of school (Vickers, 1994) and addictive behaviors (Tafà & Baiocco, 2009). Household rules and structure help establish boundaries and guidelines for parents and children, including the determination of acceptable versus unacceptable behaviors. Without behavior control including the ability to alter rules and structure to the needs of the family, the home and family environment may be described as “chaotic” (Kirsten et al., 2006, p. 522).

2.3 SUMMARY

Involving parents in the treatment of youth with mental health problems is an important agenda for several reasons. First, parenting practices and behaviors are consistently associated with positive treatment outcomes. Second, positive treatment maintenance of gains is contingent on continued application of the strategies, insights, and skills learned in therapy. Parents are usually the natural first choice in helping their youth and children maintain gains made in the clinic (Israel, Thomsen, Langeveld, & Stormark, 2007b, p. 138).

Many studies have shown a relationship between child and family mental health needs and the functioning of the overall family system. Using the areas of family functioning assessed by the Family Assessment Device, or the measurement associated with the McMaster Model of Family Functioning (Epstein et al., 1983; Miller et al., 2000), child and family mental health needs have been associated with family communication patterns, problem solving skills, roles, affective involvement and responsiveness, and behavior control. Given these research findings, it is evident that gaining a better understanding of the functioning of the family system when first providing mental health services for children, adolescents, and families is imperative.

When a family requests treatment, it is important to understand their perceptions of how their family system is functioning, including areas where the family may be experiencing increased difficulty. While many studies have examined family functioning as a predictor to a specified outcome as well as the effectiveness of treatments longitudinally on family functioning, few studies have examined family functioning in order to guide treatment. These sparse studies (e.g., Sullivan & Miklowitz, 2010; Cook-Darzens et al., 2005) have only focused on one specific diagnosis with the targeted audience being individual clinicians. However, no known studies have examined a typology of family functioning at the time of the initiation of services in a

community mental health clinic directed at clinical administrators with the purpose of developing a better understanding of the families and tailoring treatment based upon this information.

Understanding the functioning of families who seek services is imperative in guiding treatment. Individual, family, and group therapy can effectively be designed and implemented when the functioning of those initially seeking services can clearly be described. For instance, if a significant proportion of families initiating treatment are found to have difficulties in behavior control, then perhaps a parenting group could be offered at the outpatient clinic. Knowing the typology of family functioning of those initially seeking services in the community will ultimately help to meet the needs of those families. Additionally, significant improvements in clinic efficiency as well as cost cutting measures could be attained as effective group treatments and brief individual treatments could be designed and provided to families at the very start of treatment.

3.0 METHODS

3.1 TREATMENT SETTING

The setting of the present study was a non-profit, community based provider of mental health services, located within a mid-Atlantic state. The provider offers a continuum of mental health services, including child and family community based outpatient treatment. Outpatient child and family services offered at the community based clinic include individual and family therapy conducted by master's level clinicians (e.g., social workers, counselors) as well as doctoral level clinicians (e.g., clinical psychologists). Medication management services are provided by medical doctors who are trained in the specialty of psychiatry.

All outpatient services begin with an initial evaluation, which includes a 60 minute interview with a master's or doctoral level clinician. The initial evaluation is scheduled when parents or legal guardians contact the clinic and request services. Further individual and family treatment as well as medication services can then be scheduled at the clinic after this initial evaluation.

3.2 PARTICIPANTS

3.2.1 Sample

The sample for the present study consisted of 110 parents and legal guardians initiating services for their children at the outpatient clinic. This sample size accounted for a 10% attrition rate. Given that families were requested to complete only one questionnaire at one point in time during a therapy session scheduled by the family, attrition was not of concern in this study. Similar studies examining aspects of family functioning utilizing the same statistical analysis have been conducted with comparable sample sizes (Hanish & Tolan, 2007; Lobera, Garrido, Fernández, & Bautista, 2010; Miller, 1995).

All parents or legal guardians within the first three sessions of treatment for their child or adolescent at the clinic, between May, 2011 and January, 2012, were asked to participate in the study. All participants included parents or individuals who have been granted medical and educational rights of the child or adolescent by a judge. Documentation of these legal rights is requested prior to providing services at the treatment facility. The only exclusionary criteria included the inability of the parent or legal guardian to read English, as the questionnaire was a self-report measure written in the English language.

3.2.2 Sample Representativeness and Attrition

Ensuring that the participants obtained for the study were representative of the families seen at the clinic on a regular basis was imperative to the validity of the results and was monitored throughout the course of the study. The outpatient clinic regularly maintains demographic data on the clients seen at the clinic. These demographic data, or the age, race, and sex of the children

and adolescents seen at the clinic during the 2010 year, were used to ensure that the sample participants were representative of the target population. Specifically, this helped to ensure that the participants obtained in the sample were not significantly different than the individuals typically seen at the clinic on a regular basis. This supported the generalizability of the results to all of the families seen at the clinic.

3.2.3 Clinic Demographic Data

In the year 2010, 61% of the clients seen at the clinic were male and 39% of the clients were female. In regards to race, 66.95% of the clients were Caucasian, 32.47% of the clients were African American, and .58% of the clients were Asian American. In regards to age, 1% of the clients were below the age of 5, 29.92% of the clients were between the ages of 6 and 10, 43.75% of the clients were between the ages of 11 and 15, and 25.33% of the clients were between the ages of 16 and 18.

3.3 MEASUREMENT

The McMaster Family Assessment Device (FAD; Epstein et al., 1983) was used in the present study to assess family functioning at the initiation of services, or within the first three sessions of treatment (APPENDIX A

). The FAD is a 60 item self-report measure based on a Likert scale from 1 (strongly disagree) to 4 (strongly agree), with higher scores indicating poorer family functioning (Epstein et al., 1983; Georgiades et al., 2008; Miller et al., 2000). Respondents were asked to rate each of the 60 statements based on how well the statement describes their family (Epstein et al., 1983;

Georgiades et al., 2008; Miller et al., 2000). Six aspects of family functioning were assessed through the use of the FAD. These included communication skills, emotional responsiveness and involvement, behavioral control, familial roles, and problem solving capabilities (Epstein et al., 1983; Georgiades et al., 2008; Miller et al., 2000).

There is strong psychometric support for use of the FAD, as it has been described as a “well-established” measure (Alderfer et al., 2009, p. 1050). The questionnaire has been found to have excellent internal consistency among all of the subscales ($\alpha = 0.72 - 0.90$), as well as concurrent validity for use within the pediatric population (Locke-Wallace, $r = .53$; Family Unit Inventory, $r > .50$ on six of eight dimensions; Alderfer et al., 2009; Epstein et al., 1983; Georgiades et al., 2008; Miller, Epstein, Bishop, & Keitner, 1985). Additionally, correlations with the social desirability scales are low ($r = -.06 - -.15$; Miller et al., 1985; Tutty, 1995). Furthermore, the FAD has been found to have good discriminant validity between community and clinical samples, and has been able to predict the development of psychiatric disorders in children (Friedmann et al., 1997; Miller et al., 2000; Tutty, 1995). The FAD has also been found to have acceptable test-retest reliability (.66 - .76), and to be an appropriate questionnaire for use with diverse populations (Miller et al., 2000).

Some of the items are reverse coded to avoid a similar response to all of the questions and clinical cutoff values have been established to distinguish between healthy and unhealthy functioning (Miller et al., 2000; Ryan et al., 2007). Although the family functioning typology developed was based upon the results of one questionnaire, the FAD is an appropriate measure as it has been established as a reliable, valid, and thorough measure of family functioning (Alderfer et al., 2009; Epstein et al., 1983; Friedmann et al., 1997; Georgiades et al., 2008; Miller et al., 1985; Miller et al., 2000; Tutty, 1995). The questionnaire is written at a sixth grade reading level

and has been used in clinical samples in previous research (Friedmann et al., 1997; Grotevant & Carlson, 1989; Miller et al., 2000; Ryan et al., 2007; Tutty, 1995).

3.4 DESIGN

The present study was an exploratory, cross-sectional design intended to gather descriptive information about family functioning at the beginning of mental health services (Shadish et al., 2002). By obtaining this information, pertinent data regarding the functioning of families initially seeking services was obtained and analyzed to learn more about the population being served at the outpatient clinic in order to further improve services (Mark et al., 2000).

3.5 PROCEDURES

3.5.1 Prior to Data Collection

Prior to the start of data collection, the researcher met with all of the staff members at the outpatient clinic at the monthly staff meeting. Meetings with the outpatient clinic's clinical administrators also took place. Specific aspects of the study, including the procedures, were discussed. Questions and concerns were addressed directly with the staff at this time, and materials, such as the questionnaires, envelopes, and scripts (APPENDIX B) were distributed at this time.

3.5.2 Participation Timing

Participation occurred during the first three sessions of treatment. The first three sessions were chosen as the measurement period given the task of engagement in family therapy, or the development of a positive working relationship between the clinician and the family (Berg, 1994). Although the first session is technically the initiation of treatment, from a clinical perspective, the first three sessions are often spent describing and clarifying the family members' concerns and initiating a collaborative treatment plan (Ryan, Epstein, Keitner, Miller, & Bishop, 2005; Wagner, 2007). The treatment plan includes the creation of a "written contract that delineates the mutual expectations, goals, and commitments regarding therapy. The steps in this stage are: (1) orientation, (2) outlining options, (3) negotiating expectations, and (4) contract signing" (Ryan et al., 2005, p. 71) . This engagement period occurs prior to the start of the treatment phase of therapy, as presenting problems and treatment goals first need to be clearly outlined (Ryan et al., 2005). Thus, all participants were parents or legal guardians in the process of clinically initiating in therapeutic services for their children at the outpatient clinic.

3.5.3 Recruitment and Participation

During the course of the first three sessions, clinicians introduced the study to all of the eligible parents and legal guardians by reading the introductory script (Appendix B). This script reinforced the purpose of the study, the voluntary nature of the study, how the researcher maintained anonymity, and the contact information for the researcher. The FAD (Epstein et al., 1983) was also given to the parents and legal guardians at this time so that the families could review the questions to help them determine if they would like to participate in the study.

Families were asked to complete the cover page of the survey (i.e., age, race, and sex of their child) regardless of their participation in the study. However, participants were reminded of the voluntary nature of the study and could also refuse to complete the cover page. Clinicians and families were given the researcher's contact information and were asked to call the researcher with any questions or concerns.

The families were given time during the session to complete the questionnaire. To ensure that the family did not feel coerced into completing the questionnaire, additional time to complete the questionnaire was offered by the clinicians. A private and quiet cubicle area within the clinic was also offered to all families. This work space ensured that families had enough time to make a decision regarding participation and also had a private and quiet area to complete the questionnaire at their own pace.

3.5.4 Data Storage

Parents and legal guardians who participated completed the survey and sealed it in an envelope provided along with the questionnaire, thus ensuring anonymity. They were also asked to write the age, sex, and race of the child on the cover page of the survey. The cover page reminded them not to write their name or their child's name anywhere on the survey or envelope. The sealed envelope was then placed in the researcher's locked mailbox located in the clinic by the clinician. Parents and legal guardians who declined to participate, were asked if they would be willing to complete the cover page of the survey asking for the demographic information of the child. These cover pages and blank questionnaires were then sealed in an envelope by the participant. The clinician then placed the sealed envelope in the researcher's locked mailbox. Clinicians were also asked to write their name on the outside of all of the envelopes prior to

placing them in the researcher's locked mailbox. The researcher retrieved the surveys for scoring and recording purposes. The questionnaires were kept in a locked drawer in the researcher's locked office in the clinic. No names or other identifying information were associated with the questionnaires. All data were kept in a password protected computer in a locked office. The questionnaires will be shredded one year after the completion of the study.

3.5.5 Collaboration with Staff

The researcher continued, throughout the course of the study, to update the staff members and clinical administrators by sending them bi-weekly emails. The researcher was also available by phone and in person as needed to meet with staff or participants to answer any questions or address any concerns. The results will also be shared with the clinical administrators and staff after the completion of the study so that they can gain a better understanding of their clients. The tailoring of services, or the implications of the results, will also be discussed at this time.

3.6 RESEARCH OBJECTIVES

3.6.1 Objectives

The goal of the present research was to identify a meaningful typology of family functioning for families initially seeking treatment in an outpatient community mental health treatment facility. This information is lacking in the literature, and will be a source of guidance in developing a better understanding of the functioning of families initiating services. Prior to this study, research in the field focused on family functioning as a predictor to a specified outcome, such as the

experience of depression in adolescents (Feeny et al., 2009) and the effectiveness of specific treatments longitudinally in relation to family and child outcomes, such as the effectiveness of residential treatment (Preyde et al., 2011; Sunseri, 2004). Furthermore, the few studies that examined family functioning with the purpose of making treatment recommendations only focused on a few specified diagnoses, such as bipolar disorder (Sullivan & Miklowitz, 2010) and anorexia (Cook-Darzens et al., 2005) and were intended for clinicians who already tailor treatments for individuals and families (Sperry, 2005). However, no known studies had examined a typology of family functioning of those initiating outpatient family services in order to help clinical administrators design and implement appropriately tailored programs and services prior to the present study.

Although the family functioning of those first seeking treatment had not previously been examined, this type of study and analysis had been used with similar populations in an attempt to build theory and guide interventions (Milburn et al., 2009). Similar studies have examined a typology of adolescents who are homeless (Milburn et al., 2009), patterns of family involvement in kinship arrangements (Green & Goodman, 2010), the balance between work and life for mothers who work outside of the home (Losoncz & Bortolotto, 2009), resiliency in families in which one parent has a diagnosis of alcohol abuse (Coyle et al., 2009), and the characteristics of neighborhoods in relation to physical health (Li & Chuang, 2009).

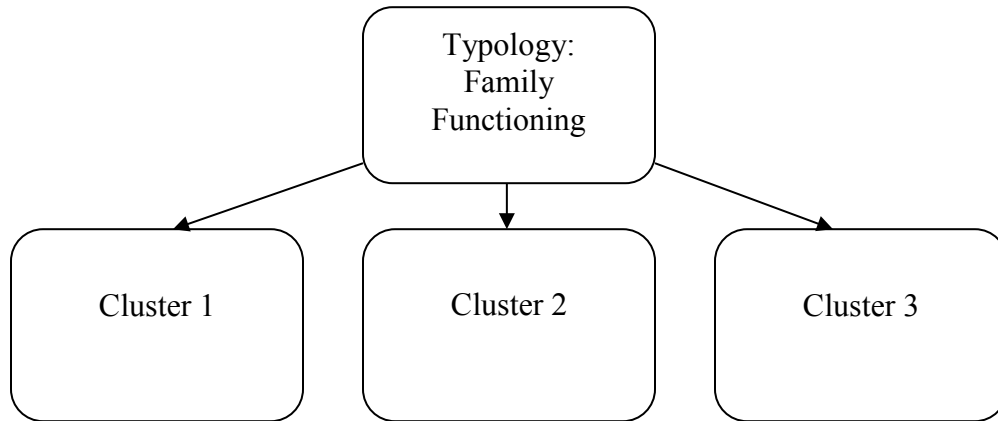


Figure 4. Typology of Family Functioning.

3.6.2 Research Questions

The present study intended to answer the following research questions:

- 1) What typology of family functioning exists for families initiating outpatient services from a community mental health treatment facility?
- 2) In what specific areas of family functioning are families obtaining unhealthy scores most frequently?

3.6.3 Hypotheses

Hypotheses are generally not presented in exploratory studies, particularly when a cluster analysis is used given that this technique does not include hypothesis testing (Julnes, 2000; Tan, Steinbach, & Kumar, 2005). In fact, many researchers using this data analysis technique only present a description of the phenomenon that they hope to depict (e.g., Losoncz & Bortolotto, 2009; Milburn et al., 2009). However, given the importance of understanding the researcher's

expectations, the following “hypotheses” are discussed, understanding that hypothesis testing was not completed in the present study (Figure 5):

Prior to the start of the study, it was hypothesized that families would be placed into one of three clusters that comprised the overarching typology of family functioning. The first cluster was suggested to represent families who scored below the clinical cutoff, or obtained healthy scores, on all six subscales. This would indicate a healthy level of functioning in all areas. Given that the families in the sample were all requesting mental health services, it was estimated that this group of individuals would represent the smallest proportion of assessed families. A second group of families was proposed to include those who scored above the clinical cutoff values on all six subscales indicating unhealthy functioning in all areas. Although it was hypothesized that this cluster would represent a larger proportion of the sample than the cluster of families with healthy functioning in all areas, it was likely that this group would be smaller than the third cluster of individuals. The third cluster of families was hypothesized to comprise families who experienced unhealthy functioning on one to five subscales. This cluster would comprise families experiencing healthy functioning in some areas, while experiencing unhealthy functioning in other areas. It was estimated that the group of families experiencing unhealthy functioning in some but not all categories would represent the largest proportion of the sample. This was expected given the fact that outpatient services represent the lowest treatment intensity of all of the community based programs (Burns et al., 1999).

These classifications were based upon previous theory (Miller et al., 2000) as well as similar studies in the field. For instance, in their study of adolescents who were newly homeless, Milburn et al. (2009) found that they could classify adolescents into protected, at-risk, and at-risk with some protective factors clusters after a cluster analysis was completed. Green and Goodman

(2010) also found that they could classify birthparent involvement in kinship arrangements into low, medium, and high involvement clusters.

Lindqvist et al. (2007) studied families seeking mental health services after a parent was diagnosed with cancer. The researchers found that affective involvement, problem solving, and communication were most predictive of healthy family functioning in both the treatment and control groups (Lindqvist et al., 2007). If these particular aspects were the most predictive of healthy family functioning overall, then it can be argued that difficulties in any one of these areas may likely lead to families initiating services. Therefore, it was hypothesized that these subscales would obtain unhealthy scores more frequently than other areas of family functioning. In fact, it was hypothesized that the cluster of families with unhealthy scores on only some of the subscales will obtain unhealthy scores on these three specific areas of family functioning (i.e., communication, problem solving, affective involvement).

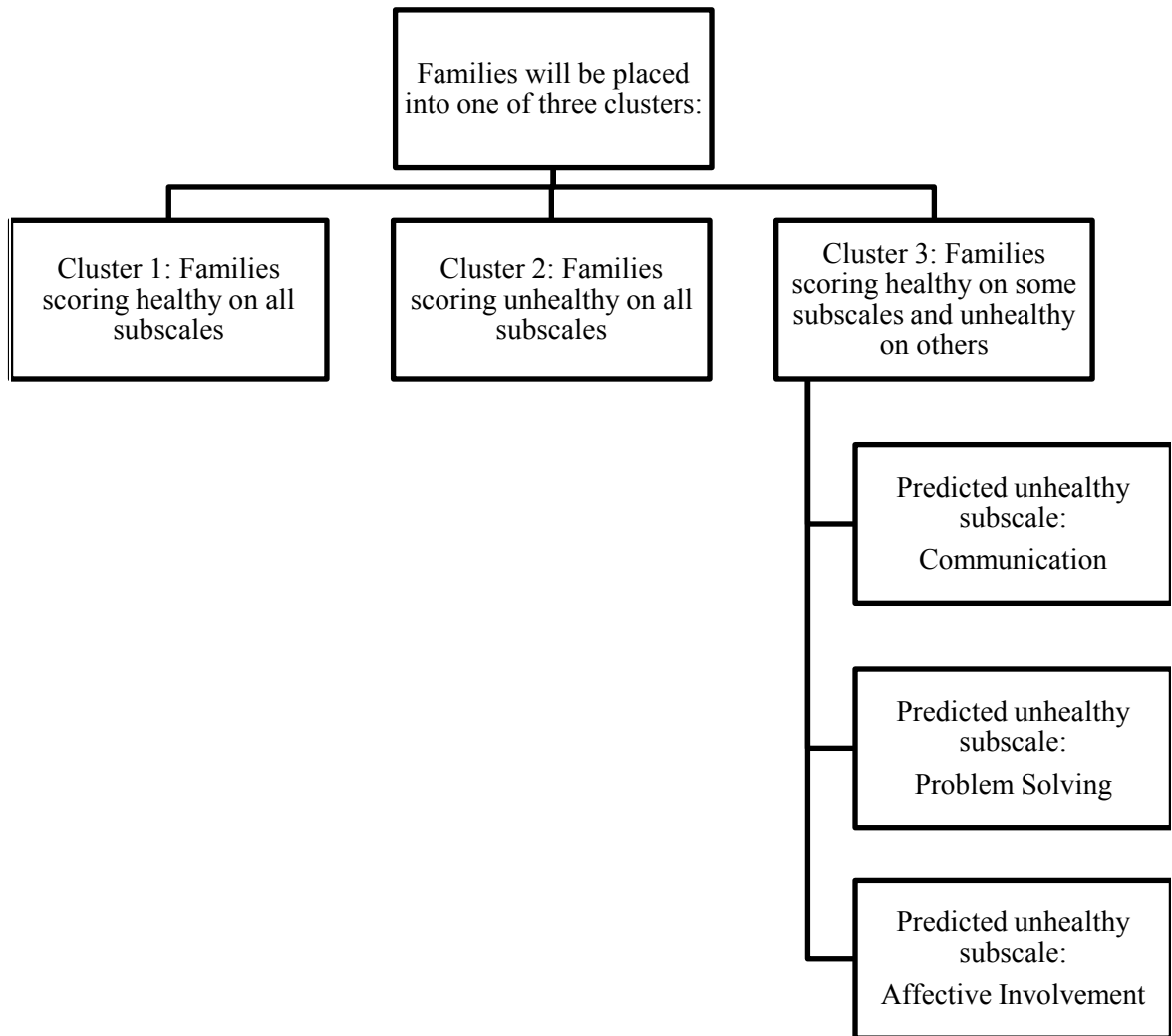


Figure 5. "Hypotheses."

3.7 DATA ANALYSIS

3.7.1 Descriptive Data

Descriptive data based upon the demographic information obtained (i.e., age, race, sex of the child or adolescent), in the form of means, standard deviations, percentages, and ranges, were analyzed in order to learn more about the population served at the clinic. These data were also used to assure that there are no concerns regarding systematic attrition bias between the participants who agreed to participate during the course of the study and the general population of families served at the clinic (Shadish et al., 2002). These analyses were examined throughout the course of the data collection period to correct for any design issues that may have contributed to systematic attrition bias (Shadish et al., 2002). Additionally, by associating each questionnaire with the clinician's name, the researcher was able to monitor for any potential design concerns. For instance, if one clinician consistently provided incomplete questionnaires, then the researcher was able to speak with the clinician to investigate potential implementation concerns.

Information regarding the age, sex, and race of the child or adolescent was important information to collect and analyze in the present study given previous findings regarding the relationship between these demographic variables and mental health treatment. For example, parents of younger boys exhibiting externalizing behaviors are more likely to seek treatment and become more involved in treatment over time (Headman & Cornille, 2008; Israel, Thomsen, Langeveld, & Stormark, 2007a). Additionally, it has been argued that youth who are minorities are underrepresented in outpatient services while overrepresented in more intensive services (Fontanella et al., 2008). Therefore, these specific demographic variables have been found to be related to the initiation of and engagement in mental health services.

3.7.2 Missing Data

The authors of the FAD (Epstein et al., 1983) have advised researchers not to use the questionnaire if less than 60% of the items are completed by the participant (Ryan et al., 2005). This rule was abided by in the present study. Imputation methods, specifically multiple imputation, can be used for questionnaires that have missing data that do not meet these criteria (Acock, 2005; Tabachnick & Fidell, 2007). Multiple imputation estimates a probability distribution for each participant based upon the participant's available data (Acock, 2005; Tabachnick & Fidell, 2007). Then, from each participant's distribution, multiple complete datasets are generated (Acock, 2005; Tabachnick & Fidell, 2007). Parameter estimates are then pooled across the multiple datasets (Acock, 2005; Tabachnick & Fidell, 2007). This method is preferred over mean substitution methods as multiple imputation has been found to maintain natural variability in the dataset (Acock, 2005; Tabachnick & Fidell, 2007).

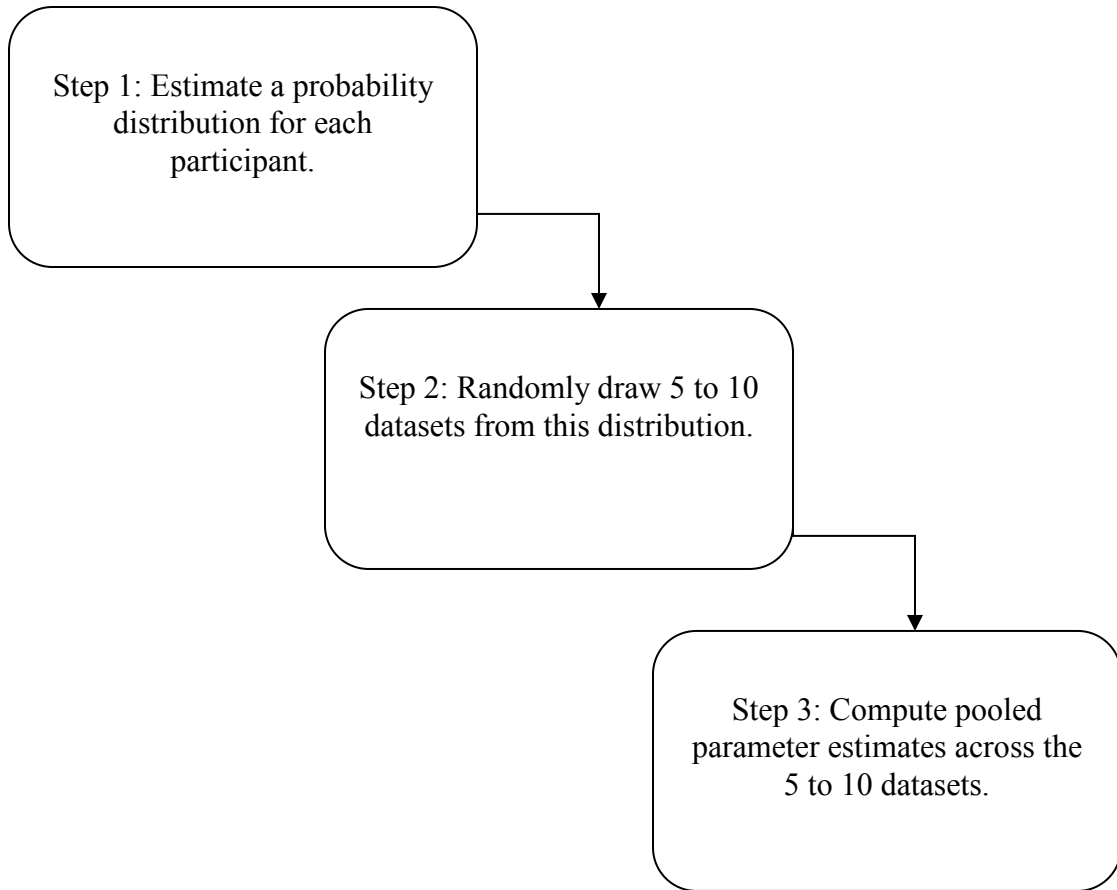


Figure 6. Multiple Imputation (Acock, 2005, p. 1019; Tabachnick & Fidell, 2007).

3.7.3 K-Means Cluster Analysis

Cluster analysis, which “seeks to identify...categories into which phenomenon can be placed” (Julnes, 2008, p. 543) was the statistical technique utilized in this study to identify meaningful clusters of families seeking services at the outpatient clinic. The goal of the analysis was to identify meaningful clusters of family functioning based upon subscale scores on the FAD (Epstein et al., 1983), such that the variation observed within the clusters was smaller than the variation observed between the clusters (Julnes, 2008; Mark et al., 2000).

The data from the six subscales of the FAD (Epstein et al., 1983) were used to develop these clusters. Each subscale was comprised of multiple questions that assess a particular aspect of family functioning (e.g., communication, problem solving, etc.). The mean of the responses to the subscale questions was calculated and compared to previously established clinical cutoff values to determine whether the family's functioning on that particular subscale was considered "healthy" or "unhealthy" (Miller et al., 2000; Ryan et al., 2005). Therefore, each participant had six scores, each comprising one mean score from all of the subscale questions.

Based upon previous research, it was hypothesized that three clusters would emerge (i.e., individuals obtaining healthy mean scores on all six subscales, families obtaining healthy mean scores on some subscales and unhealthy mean scores on others; and families obtaining unhealthy mean scores on all six subscales). Through the use of the k-means cluster analysis procedures in SPSS software (IBM, 2012), the centroids (i.e., centers) of these three hypothesized clusters were generated (Julnes, 2000; Tan et al., 2005). The clusters were then created by placing all of the participants into a particular cluster (Julnes, 2000; Tan et al., 2005). The specific cluster in which the participant was placed was determined by the distance between the participant's mean scores on the subscales and the centroid of the cluster (Julnes, 2000; Tan et al., 2005). Then, with the addition of these new participants into the clusters, cluster centroids were recalculated (Julnes, 2000; Tan et al., 2005). The adding of participants and the recalculation of the cluster centroids reoccurred until the clusters stabilized (Julnes, 2000; Tan et al., 2005). The composition of these clusters were then interpreted and condensed into a typology of family functioning (Julnes, 2000; Tan et al., 2005).

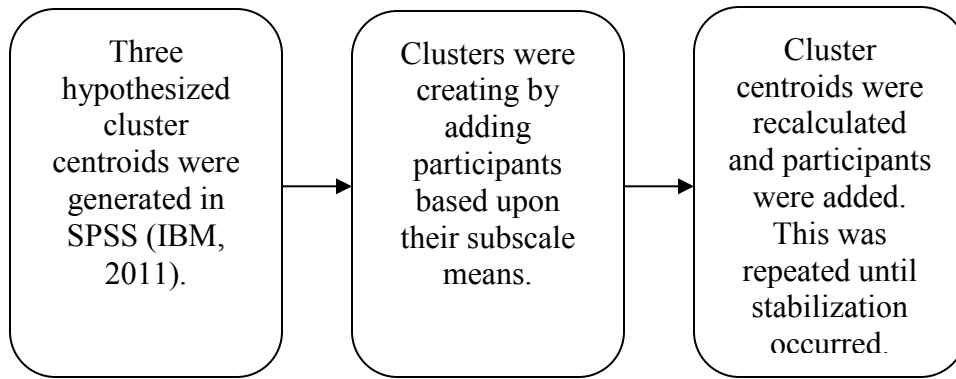


Figure 7. Cluster Analysis (Julnes, 2000; Tan et al., 2005, p. 497).

4.0 RESULTS

4.1 DESCRIPTIVE DATA

4.1.1 Participants

There were 103 participants who took part in the study. Of the 110 participants sampled, seven declined to complete the FAD but agreed to provide the age, race, and sex of their child. This participation includes a 6.36% attrition rate, and the present study allotted for a 10% attrition rate. The participants were recruited by the clinicians employed in the clinic between May, 2011 and January, 2012 during one of the first three treatment sessions.

The age, race, and sex of the children in the study were compared to the demographic data obtained from the clinic during the 2010 year. There were not significant demographic differences between the participants of the study as compared to the population served at the clinic.

4.1.2 Age

The children of the participants in the study had a mean age of 11.94 years and a standard deviation of 3.25 years. The range varied from 5 to 17 years of age. Among those sampled, 1% of the children were below the age of 5, 29.3% were between the ages of the 6 and 10, 54.3% were between the ages of 11 and 15, and 15.4% were between the ages of 16 and 18 years.

A one sample t-test was utilized to ensure that the mean age of the children in the study was not significantly different than the mean age for the population of the clinic. The statistical analysis indicated that the children in the study were not significantly different than the population of the clinic in regards to age, $t(102) = -1.838, p = .069$.

4.1.3 Sex

In regards to sex, 54.4% of the sample was male and 45.6% was female.

A one way chi-square test was performed to test whether or not the gender distribution of the children in the study was significantly different than the gender distribution for the population of the clinic. The statistical analysis revealed that the gender distribution for the study was not significantly different than that of the population, $\chi^2(1, n = 103) = 2.235, p = .135$.

4.1.4 Race

In regards to race, 63.1% of the sample was Caucasian, 35.9% was African American, and 1% was Asian American.

A one way chi-square test was performed to test whether or not the racial distribution of the children in the study was significantly different than the racial distribution for the population of the clinic. The statistical analysis revealed that the racial distribution for the study was not significantly different than that of the population, $\chi^2(2, n = 103) = .877, p = .645$.

4.2 MISSING DATA

Among the 103 completed questionnaires, eight participants did not answer all 60 questions on the FAD. The authors of the FAD (Epstein et al., 1983) have advised researchers not to use the questionnaire if fewer than 60% of the items are completed by the participant (Ryan et al., 2005). In this study, the advisement of Epstein et al. (1983) was heeded. Given that no participant had fewer than 60% of the items completed, the subscales were calculated without the missing items as instructed by the authors of the FAD (Ryan et al., 2005). For example, if a participant did not answer one of the six problem solving questions that comprise the problem solving subscale of the FAD, the mean of the problem solving subscale was calculated with the five questions that were answered (i.e., the sum of the five questions was divided by five, not six). Therefore, multiple imputation was not required for the missing data in the present study.

4.3 SCALE DESCRIPTION

4.3.1 Cronbach's Alpha

Cronbach's alpha is a measure of reliability, or the internal consistency among the items on a scale (Keppel & Wickens, 2004). Values above 0.7 are considered acceptable (Keppel & Wickens, 2004). In this study, a Cronbach's alpha score was computed for each scale: 1) problem solving: $\alpha = .779$, 2) communication: $\alpha = .745$, 3) roles: $\alpha = .748$, 4) affective responsiveness: $\alpha = .774$, 5) affective involvement: $\alpha = .830$, and 6) behavior control: $\alpha = .769$.

4.3.2 Descriptive Statistics for Each Scale

Descriptive statistics were computed for each composite score in order to better describe and understand each scale. This information is displayed in the table below.

Subscale	Mean	Standard Deviation	Minimum	Maximum	Clinical Cutoff
Problem Solving	2.109	.511	1.00	3.83	2.20
Communication	2.156	.438	1.11	3.22	2.20
Roles	2.298	.431	1.27	3.36	2.30
Affective	2.070	.556	1.00	4.00	2.20
Responsiveness					
Affective	2.226	.566	1.00	3.71	2.10
Involvement					
Behavior Control	1.802	.450	1.00	3.00	1.90

Table 1: Descriptive Statistics for Each Scale.

4.4 K-MEANS CLUSTER ANALYSIS

4.4.1 Review of Hypotheses

A k-means cluster analysis was utilized to identify and describe the specific clusters of family functioning of the families initiating services at the clinic. The data from the six subscales of the FAD (Epstein et al., 1983) were used to develop these clusters. Each subscale is comprised of multiple questions that assess a particular aspect of family functioning (e.g., communication, problem solving, etc.). For each participant, the mean of the responses to the subscale questions was calculated and compared to previously established clinical cutoff values to determine whether the family's functioning on that particular subscale was considered "healthy" or "unhealthy" (Miller et al., 2000; Ryan et al., 2005). Therefore, each participant had six scores, each representing one mean score from all of the subscale questions. Based upon previous research, it was hypothesized that three clusters would emerge (i.e., families obtaining healthy mean scores on all six subscales, families obtaining healthy mean scores on some subscales and unhealthy mean scores on the others; and families obtaining unhealthy mean scores on all six subscales). Furthermore, among those families who obtained healthy scores on some of the subscales and unhealthy scores on the others, it was hypothesized that the unhealthy subscales would include communication, problem solving and affective involvement based upon previous literature suggesting that these areas of family functioning are most predictive of healthy functioning (Lindqvist et al., 2007).

4.4.2 Results of K-Means Cluster Analysis

After completing the k-means cluster analysis, three clusters emerged. These clusters included scores of families who obtained healthy scores on all of the subscales, of families who had unhealthy scores on all of the subscales, and of families who obtained healthy scores on only some of the subscales while obtaining unhealthy scores on the others.

4.5 DESCRIPTION OF THE CLUSTERS

4.5.1 Cluster 1: Healthy Functioning

The first cluster contained data on families who obtained healthy scores on all of the six subscales of the FAD (i.e., problem solving, communication, affective involvement, affective responsiveness, behavior control, and roles). This cluster contained 22 cases and represented 21.36% of the sample, making it the smallest cluster of the study.

The mean age of the children was 12.18 years with a standard deviation of 2.58 years. The age range was from 6 to 17 years of age. In regards to sex, 54.5% of the cluster included male children and 45.5% of the cluster included female children. In regards to race, 68.2% of the children were Caucasian and 31.8% of the children were African American.

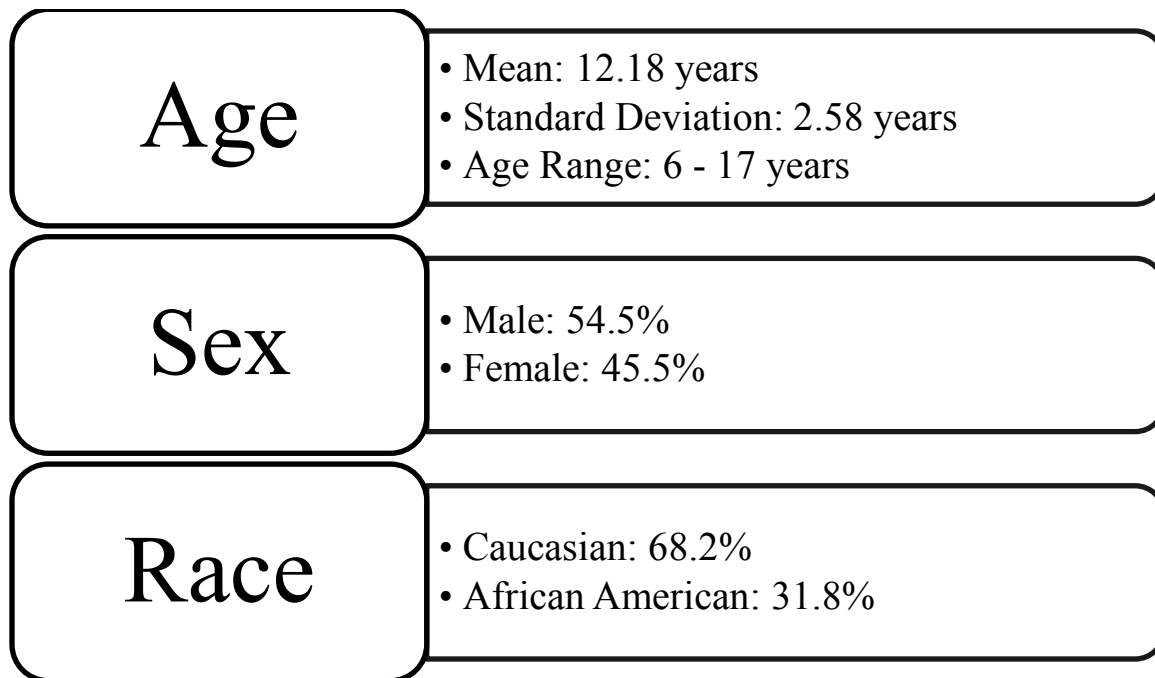


Figure 8. Cluster 1: Healthy Functioning.

4.5.2 Cluster 2: Unhealthy Functioning

The second cluster contained data on families who obtained unhealthy scores on all six of the FAD subscales (i.e., problem solving, communication, affective involvement, affective responsiveness, behavior control, and roles). This cluster contained 23 cases and accounted for 22.33% of the sample.

The mean age of the children who were included in this cluster was 14.09 years with a standard deviation of 2.80 years. The age range was from 8 to 17 years. The cluster was comprised of 69.6% male children and 30.4% female children. In regards to race, the cluster contained 43.5% of children who were Caucasian and 56.5% of children who were African American.

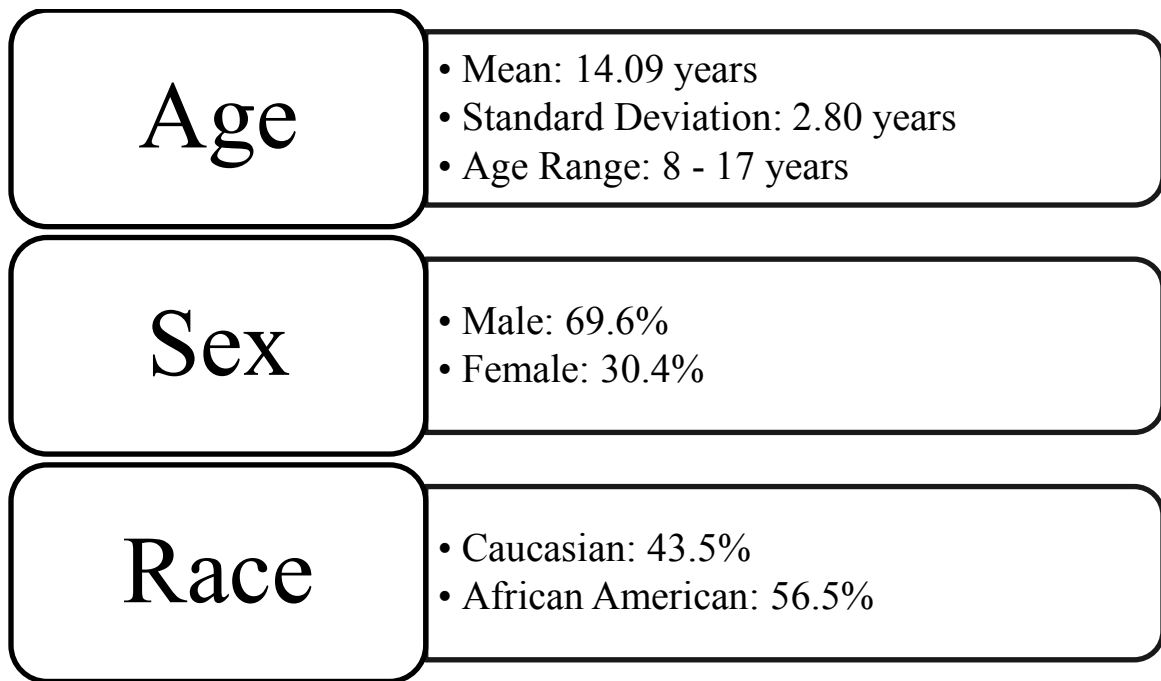


Figure 9. Cluster 2: Unhealthy Functioning.

4.5.3 Cluster 3: Healthy and Unhealthy Functioning

The third, and largest, cluster contained data on participants who had healthy scores on some of the six FAD subscales and unhealthy scores on others (i.e., problem solving, communication, affective involvement, affective responsiveness, behavior control, and roles). This cluster contained 58 families and represented 56.31% of the sample.

The mean age of children in this cluster was 11.00 years with a standard deviation of 3.26 years. The age range varied from 5 to 16 years. In regards to sex, 48.3% of the sample consisted of male children while 51.7% of the cluster consisted of female children. Sixty-nine percent of the cluster consisted of children who were Caucasian, 29.3% of the cluster contained children

who were African American, and 1.7% of the cluster contained children who were Asian American.

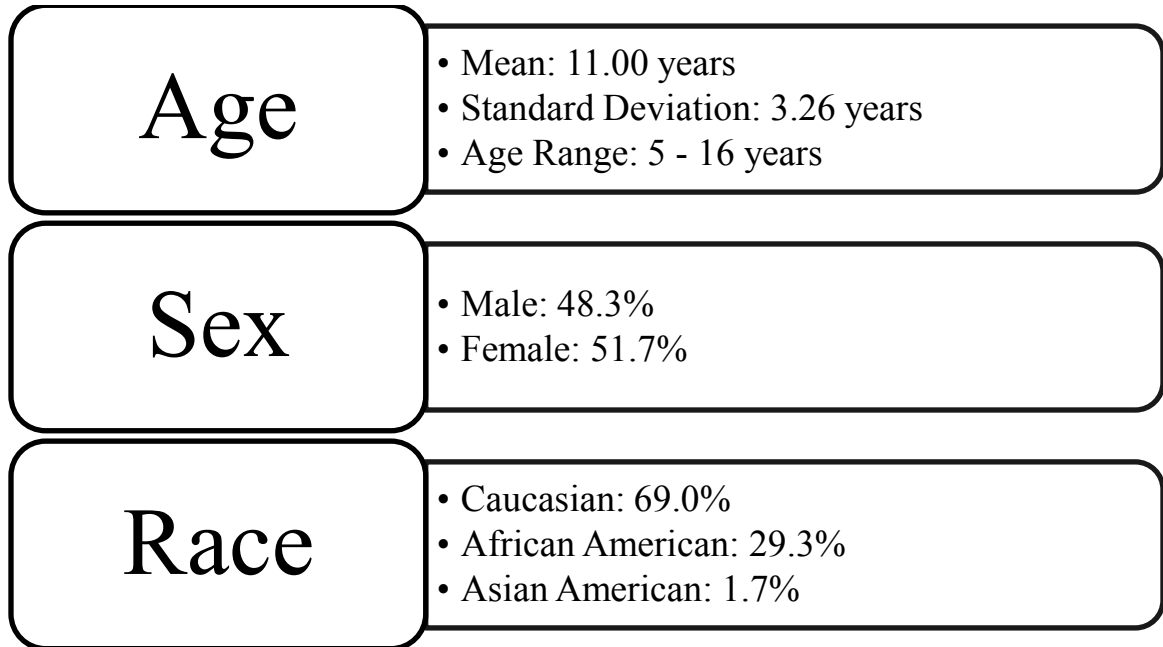


Figure 10. Cluster 3: Healthy and Unhealthy Functioning.

Among the subscales for this cluster, two were found to be in the unhealthy range for the majority of families: 1) affective involvement and 2) roles. Fifty percent of families obtained a healthy score for communication while 50% obtained unhealthy scores in this domain. The majority of participants obtained healthy scores in the areas of problem solving, affective responsiveness, and behavior control.

Subscale	Healthy	Unhealthy
Problem Solving	70.7%	29.3%
Communication	50.0%	50.0%
Roles	48.3%	51.7%
Affective Involvement	24.1%	75.9%
Affective Responsiveness	75.9%	24.1%
Behavior Control	70.7%	29.3%

Table 2. Cluster 3: Descriptive Data for Each Subscale.

4.6 DESCRIPTION OF SUBSCALES FOR ALL PARTICIPANTS

After examining each subscale for all 103 participants who completed the FAD, the majority of participants obtained unhealthy scores on three subscales: 1) communication, 2) roles, and 3) affective involvement. The majority of families in the study obtained healthy scores on the problem solving, affective responsiveness, and behavior control subscales.

Subscale	Healthy	Unhealthy
Problem Solving	65%	35%
Communication	49.5%	50.5%
Roles	49.5%	50.5%
Affective Involvement	35.9%	64.1%
Affective Responsiveness	65%	35%
Behavior Control	62.1%	37.9%

Table 3. Descriptive Data on Each Subscale for All Participants.

4.7 DIFFERENCES BETWEEN THE CLUSTERS

A one-way analysis of variance with post-hoc pairwise comparisons, using the Scheffé adjustment, was computed to identify the differences between the three clusters on the six scales. On all six scales, there were significant differences between the clusters (Figure 11).

In regards to problem solving, there were significant differences between the three clusters, $F(2, 100) = 34.415, p < .001, \eta^2 = .408$. The cluster with only healthy scores obtained a significantly lower ($M = 1.584, SE = .085$) score on the problem solving scale than the cluster with both healthy and unhealthy scores ($M = 2.127, SE = .052$), which scored significantly lower than the cluster with only unhealthy scores ($M = 2.566, SE = .083$).

Significant differences were found between the three clusters in relation to the communication scale as well, $F(2, 100) = 71.690, p < .001, \eta^2 = .589$. The cluster with only healthy scores obtained a significantly lower ($M = 1.606, SE = .060$) score on the communication scale than the cluster with both healthy and unhealthy scores ($M = 2.183, SE = .037$), which scored significantly lower than the cluster with only unhealthy scores ($M = 2.615, SE = .059$).

There were also significant differences between the clusters in regards to roles, $F(2, 100) = 35.302, p < .001, \eta^2 = .414$. The cluster with only healthy scores obtained a significantly lower ($M = 1.824, SE = .071$) score on the roles scale than the cluster with both healthy and unhealthy scores ($M = 2.339, SE = .044$), which scored significantly lower than the cluster with only unhealthy scores ($M = 2.648, SE = .070$).

Significant differences between the clusters were found after examining the affective responsiveness scale, $F(2, 100) = 89.868, p < .001, \eta^2 = .643$. The cluster with only healthy scores obtained a significantly lower ($M = 1.470, SE = .072$) score than the cluster with both healthy and unhealthy scores ($M = 2.009, SE = .044$), which scored significantly lower than the cluster with only unhealthy scores ($M = 2.797, SE = .070$).

Similarly, significant differences between the clusters were found after examining the affective involvement scale, $F(2, 100) = 60.312, p < .001, \eta^2 = .547$. The cluster with only healthy scores obtained a significantly lower ($M = 1.481, SE = .082$) score than the cluster with both healthy and unhealthy scores ($M = 2.321, SE = .051$), which scored significantly lower than the cluster with only unhealthy scores ($M = 2.698, SE = .082$).

On the behavior control scale, significant differences were found between the clusters, $F(2, 100) = 76.041, p < .001, \eta^2 = .6037$. The cluster with only healthy scores obtained a significantly lower ($M = 1.313, SE = .061$) score on the behavior control scale than the cluster

with both healthy and unhealthy scores ($M = 1.767, SE = .038$), which also scored significantly lower than the cluster with only unhealthy scores ($M = 2.357, SE = .060$).

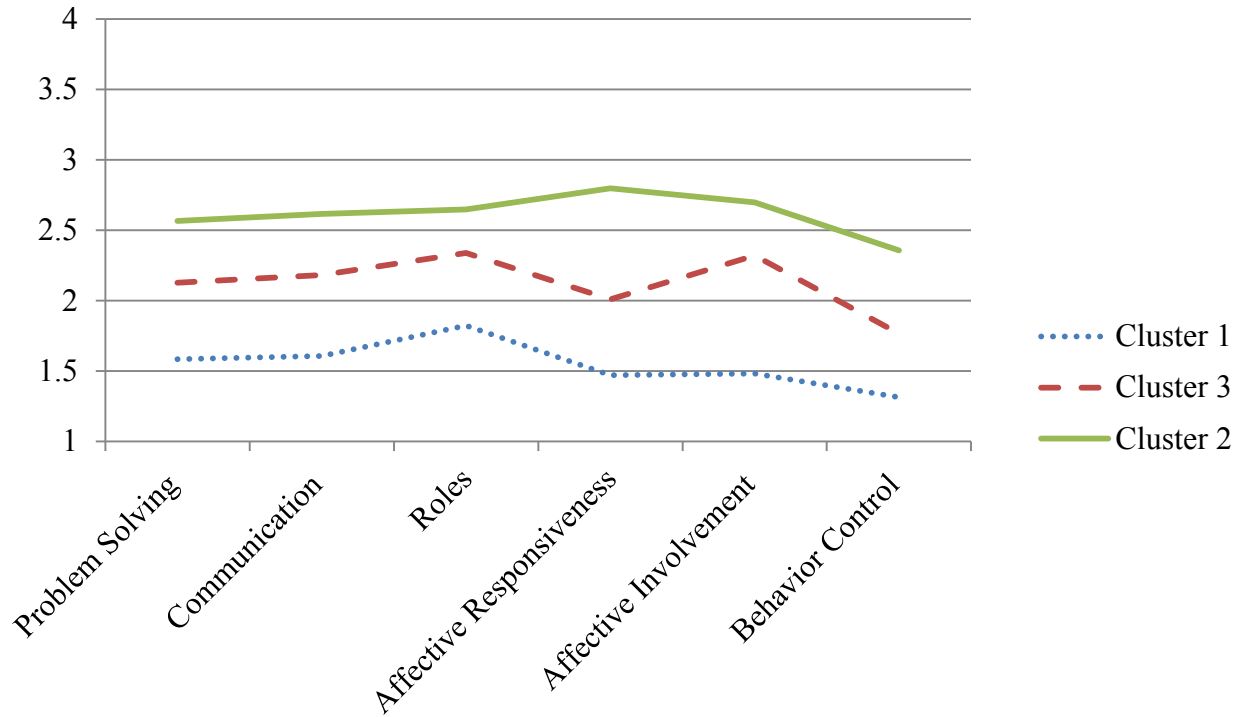


Figure 11. One-Way ANOVA

5.0 DISCUSSION

5.1 PURPOSE OF THE PRESENT STUDY

The purpose of the present study was to explore and describe the functioning of families as they initiate outpatient community mental health services in an effort to better understand their needs and ultimately to tailor the services to meet these needs. Two research questions were posed in the present study:

- 1) What typology of family functioning exists for families initiating outpatient services from a community mental health treatment facility?
- 2) In what specific areas of family functioning are families obtaining unhealthy scores most frequently?

This study utilized an exploratory analysis, specifically a k-means cluster analysis, in order to identify and describe a typology of family functioning as perceived by families initiating outpatient mental health services. Although family functioning has been a popular topic in the research field, no known studies have examined family functioning in a general outpatient clinic in an effort to assist clinical administrators in tailoring services to meet the needs of the clients who are initiating services. Given that this study is a first in the field, the results have both pertinent research and clinical implications.

5.2 DESCRIBING THE TYPOLOGY

As predicted, based upon previous research in similar fields, three clusters of family functioning emerged in the present study to include families with healthy family functioning on all of the subscales of the FAD, families with unhealthy functioning on all of the subscales, and families with healthy functioning on some of the subscales and unhealthy functioning on the others.

5.2.1 Cluster 1: Healthy Functioning

The smallest cluster contained data on families who scored below the clinical cutoff on all six of the FAD subscales to include problem solving, communication, roles, affective involvement, affective responsiveness, and behavior control. This finding indicates that these families were experiencing healthy functioning in all six areas of family functioning that were assessed. This cluster represented 21.36% of the sample. It was predicted that this cluster would contain the smallest proportion of participants given that the families in the study were initiating mental health services. It could be assumed that they were seeking services for some child and/or family concerns experienced within the family setting.

This cluster contained data on families whose children were similar in regards to the assessed demographic characteristics (i.e., age, race, and sex of the children) to the entire sample and to the clinic population in general. The mean age was approximately 12 years, the cluster was split fairly evenly among males (54.5%) and females (45.5%), and the majority of the participants were Caucasian (68.2%).

5.2.2 Cluster 2: Unhealthy Functioning

The second cluster that emerged contained data on families who scored above the clinical cutoff on all six subscales on the FAD, indicating unhealthy functioning in all of the assessed areas of family functioning. This particular cluster was larger than the cluster of families with healthy functioning in all areas, but only by one family. It was predicted that this cluster would be larger than the cluster of families with healthy functioning in all areas but smaller than the cluster of families with healthy functioning in some but not all areas. This prediction was informed by Burns et al. (1999) who discussed that, although families are seeking services for some mental health concern experienced within the family setting, outpatient services are the least intensive services in the continuum of care.

This second cluster had demographic characteristics that distinguished it from the other two clusters as well as the sample and general clinic population. This cluster had an older mean age of 14 years, and the majority of children in this cluster were male (69.6%) and African American (56.5%). These findings support previous research that found that parents of males exhibiting externalizing behaviors are more likely to seek treatment and become more involved in treatment over time (Headman & Cornille, 2008; Israel, Thomsen, Langeveld, & Stormark, 2007a). However, the male children in these previous studies were found to be younger males, while in this cluster, the mean age was older than that of the mean age of the entire sample. In regards to race, it has been found in previous research that youth who are minorities are underrepresented in outpatient services while overrepresented in more intensive services (Fontanella et al., 2008). Given that the majority of children in the study were Caucasian, the findings of the present study support this previous research. However, this previous research

does not explain why this specific cluster included children who were predominantly African American.

In general, researchers have found that youth who are minorities have barriers to the appropriate community treatment options (Fontanella et al., 2008). Perhaps this second cluster contained children who were not able to access appropriate levels of care. It is possible that these children require higher levels of care that were not available or accessible to the families within their communities. Although youth who are minorities may be overrepresented in higher levels of care, there may also be a proportion of youth who require higher levels of care but are unable to access more appropriate services. This cluster suggests several clinical implications, especially the need for higher levels of care, such as in home family based services.

5.2.3 Cluster 3: Healthy and Unhealthy Functioning

The third cluster that emerged in the study contained data on families who scored above the clinical cutoff for some of the FAD subscales but below the clinical cutoff for other subscales, indicating healthy functioning in some but not all areas of family functioning. This cluster represented 52.72% of the sample, or the largest cluster found in the study as predicted.

In regards to the assessed demographic variables, this cluster was similar to the first cluster and to the entire sample of participants. The mean age was 11 years, the cluster was split fairly evenly among males (48.3%) and females (51.7%), and the majority of the participants were Caucasian (69%).

It was predicted that, in this cluster, a majority of participants would score above the clinical cutoff on three subscales, indicating unhealthy functioning in these three areas: 1) communication, 2) problem solving, and 3) affective involvement. These areas were found to be

predictive of healthy family functioning in previous studies (Lindqvist et al., 2007). However, only two subscales were found to indicate unhealthy family functioning for a majority of participants in this cluster: 1) affective involvement and 2) roles. Fifty percent of the families in this cluster were found to have unhealthy communication patterns, while the other 50% were found to have healthy communication patterns.

Although it was predicted that a majority of families within this cluster would experience unhealthy functioning in the area of problem solving, perhaps this cluster of families initiating services is significantly different in this area of family functioning from families who do not seek services. Since seeking services can be defined as the use of effective problem solving skills (Geller & Biebel, 2006), then this could be identified as a strength for the families entering the clinic; they have already taken the first step in solving their problem by requesting professional help. Similarly, it is possible that communication was found to be a strength for 50% of the families in this cluster as seeking therapy for family related concerns requires at least one family member to be open to talking about their concerns and an ability to explain these issues to another individual.

The area of roles was found to be problematic for a majority of families in this cluster. This aspect of family functioning is defined as “recurrent patterns of behavior by which individuals fulfill family functions” (Miller et al., 2000, p. 171) and includes a number of questions on the FAD targeted at the division of tasks and responsibilities within the family setting. If family members are not fulfilling their assumed duties, both physically (e.g., chores) and emotionally (e.g., role of parent), then this may be a reason to seek treatment due to the perceived imbalance within the family setting.

5.2.4 Subscales for all Participants

The areas of communication, roles, and affective involvement were found to be areas of family functioning in which a majority of families in the study were found to have difficulties. However, only the area of affective involvement resulted in a large proportion of families experiencing difficulties (64.1% unhealthy versus 35.9% healthy). Affective involvement is defined as the “degree to which the family as a whole shows interest in and values the activities and interests of individual family members” (Miller et al., 2000, pp. 171 -172). This aspect of family functioning describes the ways in which family members show appropriate interest in others, while maintaining appropriate distance to allow for independence (Miller et al., 2000). Affective components have been found to be related to family functioning in various child and adolescent mental health diagnoses (Ghanizadeh & Shams, 2007; McNamara & Loveman, 1990), the experience of having a parent with a mental health (Du Rocher Schuldlich et al., 2008) and medical diagnosis (Lindqvist et al., 2007), as well as the expression of anger and aggression within the family setting (Avci & Güçray, 2010; Duane et al., 2003). The ability to correctly identify emotions, regulate emotions, show interest in others while maintaining adequate space for independence, and appropriately handle conflict are all important concepts children learn first within their family setting and apply in adulthood (Koerner & Fitzpatrick, 1997; Miller et al., 2000). The ability to show interest in one another appropriately and regulate emotions is an important factor in the ability of a family to function. This finding has clinical implications for the treatment offered in the clinic.

5.3 CLINICAL IMPLICATIONS

5.3.1 Cluster 1: Healthy Functioning

Why would a family enter treatment when they are scoring below the clinical cutoff (i.e., healthy) on all of the subscales of the FAD? This is an important question in the discussion of the clinical implications for this cluster. Perhaps families within this cluster are experiencing concerns in one or more of the areas of family functioning but not to the degree that would be described as “unhealthy” or “clinical.” Interestingly, the families in this cluster not only scored below the clinical cutoff on all six subscales, but also had significantly lower mean scores on all six subscales when compared to the families in the other two clusters. These findings would suggest the need for a thorough assessment of the family’s needs and concerns. Additionally, families in this cluster may be experiencing a stressor or change that, despite upsetting the family balance, has not greatly affected the core functioning of the family system. For example, the loss of a loved one can have a significant impact on the family system (Davies, Spinetta, Martinson, McClowry, & Kulenkamp, 1986). However, the loss and associated grief may not upset the healthy components of the functioning of the family members. Specifically, a family may need help in the grieving process and life transition, but the essential workings of the family (e.g., communication, problem solving, behavior control, etc.) may not be impacted on a clinical level.

One clinical implication for this cluster of families scoring below the clinical cutoff on all of the subscales of the FAD includes incorporating the families’ strengths into treatment, or using a strengths based or solution focused approach (Berg, 1994; de Shazer, 1985). By using the families’ strengths, such as problem solving or communication, the focus can shift from one of dysfunction to that of potential solutions. For example, in identifying past and current successes

of the family effectively navigating through difficult times, the family can become empowered to use these natural skills to help them work through the current concerns that brought them to treatment (Berg, 1994).

Additionally, when life transitions have brought families into care, it is essential to obtain a complete history and assessment of the family system. An example of such an assessment is known as transitional mapping in which the family “pinpoints the impact of social and cultural changes that may be transforming a family” (Hanna & Brown, 2004). In viewing family functioning in this manner, the therapist is able to identify the initiation of treatment as a response to a transition in the family’s life versus a “dysfunction” or “diagnosis” (Haley, 1980). The clinician therefore designs brief services that focus on helping families through this transition or stressor so that they may accomplish the treatment goal of experiencing healthy functioning without the help of the therapist.

5.3.2 Cluster 2: Unhealthy Functioning

The crucial clinical implication for families seeking services who are scoring in the “clinical” range on all aspects of family functioning and obtaining higher mean scores on all six subscales when compared to the families in the other two clusters is to determine whether or not the level of care they are seeking is most appropriate. On the continuum of care, outpatient treatment is considered the least intensive service and includes a maximum of weekly 45 minute sessions with a therapist (Burns et al., 1999). More intensive services include in home services (i.e., wraparound, family based services), partial hospitalizations, and inpatient hospitalizations (Burns et al., 1999). Perhaps families in this cluster seeking outpatient services are more likely to benefit

from family based interventions in which therapists come directly to the family's home several times per week (Burns et al., 1999; Berg, 1994).

Furthermore, advocacy for this cluster of families is imperative. The finding that the families in this cluster include children who are predominantly older, male, and African American is significant. Advocacy for removing "institutional barriers" including "the location of mental health services, their formality...the way they advertise their services...and the lack of culturally diverse practitioners" (Gladding, 2002, p. 319) is crucial in ensuring that families in need of particular services are able to receive them promptly and efficiently.

5.3.3 Cluster 3: Healthy and Unhealthy Functioning

The clinical implications for the cluster of families who scored below the clinical cutoff for some, but not all of the areas of family functioning are very important considering the fact that this cluster described a majority of the participants in the study. Given that all of these families exhibited strengths in multiple areas, it is imperative that clinicians assess for strengths at the beginning of treatment and employ a strengths based or solution focused approach (Berg, 1994; de Shazer, 1985) to treatment. Berg argues that a strengths based approach to family work empowers families and is not only cost-effective but also a compassionate approach to treatment:

By involving the family as a partner in the decision-making and goal-setting process and using the family's existing resources...services strive to enhance the family members' sense of control over their own lives. The result is that family members feel an increased sense of competency in conducting their lives and can create a safe and nurturing environment for their children while maintaining the unique cultural and ethnic characteristics of their family unit. With such help, families are able to live independently with a minimum of outside interference (p. 2).

Emphasizing a family's strengths and using them in the treatment process assists families in feeling empowered and may help them identify the solutions that will be the most effective

within their family setting. Additionally, when the clinician focuses on strengths, this changes the family's focus from "dysfunctional" to "functional" (Gladding, 2002).

The finding that roles is an important area of family functioning to address in treatment for a large portion of families illuminates the need for a thorough assessment. It is critical for therapists to identify the structure of the family system, including the tasks associated with or assigned to each family member. Clinicians must remember that the structure of the family system and the tasks, both physical and emotional, associated with each role will not be the same for each family. Cultural and ethnic factors greatly influence each family system. Training clinicians in structural family therapy may help clinicians understand the important concept of roles. According to Minuchin who developed structural family work:

A major thesis of structural theory is that a person's symptoms are best understood as rooted in the context of family transaction patterns. The family is seen as the client. The hope is that through structuring or restructuring the system all members of the family and the family itself will become stronger...Consequently, lasting change is dependent on altering the balance and alliances in the family so that new ways of interacting become realities (Gladding, 2002, p. 202; Minuchin, 1974).

There are many techniques that therapists may use to help the family enact change. For example, restructuring the system includes "altering the existing hierarchy and interaction patterns so that problems are not maintained" (Gladding, 2002, p. 208). Identifying the family's "ideal" structure is pertinent in treatment as the therapist should not prescribe a structure to the family based on societal norms.

5.3.4 Clinical Implications for All Participants

The findings indicated that a large proportion of families experienced difficulty in the area of affective involvement. Affective involvement is defined as the "degree to which the family as a

whole shows interest in and values the activities and interests of individual family members” (Miller et al., 2000, pp. 171-172). This aspect of family functioning describes the ways in which family members show appropriate interest in others, while maintaining appropriate distance to allow for independence (Miller et al., 2000). Interestingly, for both the third cluster and for all participants in general, the proportion of families in the unhealthy range for affective involvement corresponded to the proportion of families in the healthy range for affective responsiveness. For example, for all participants in the study, 64.1% of families scored within the unhealthy range for affective involvement while 65% of families scored within the healthy range for affective responsiveness. In order to understand the clinical implications for this finding, it is important to examine the specific statements on the FAD that are associated with these two subscales. Affective involvement includes statements such as: (1) We are too self-centered, (2) We get involved with each other only when something interests us, and (3) Even though we mean well, we intrude too much into each other’s lives. Affective responsiveness includes statements such as: (1) We are reluctant to show our affection for each another, (2) Some of us just don’t respond emotionally, and (3) We cry openly. Perhaps families seek treatment when the individual family members feel as though they are no longer important to the family system or are no longer valued or respected. When family members begin to become egocentric or cross emotional boundaries, then there is a possibility that the family system as a whole suffers.

Helping families to adjust the affective environment within their family setting may include several different approaches to treatment. As previously stated, a thorough assessment of the family is needed to better understand the concerns and needs of each family member. This assessment may include a mental health assessment of each family member given that each

family member's experience of mental health concerns can impact the family system as a whole. For example, Avci and Güçray (2010) found that adolescents who act out violently often have experienced family members with psychological concerns, aggressive acts, and alcohol use, all of which can influence the expression and regulation of emotions in the home. If multiple family members are experiencing mental health concerns, it may be advised to continue with family therapy while helping each family member obtain their own individual support, either in individual treatment or in a support group.

Budman and Gurman (1988) offer two treatment suggestions when affective involvement is the predominant concern within a family system, including assessing for affective concerns and making this area the immediate focus of therapy if these concerns are present within the family system. They argue that “at times, interventions that successfully enhance attachment and bonding preclude the need for more rational problem-solving work” (p. 156). Additionally, helping family members to learn emotion regulation skills is equally important. However, clinicians should understand that the desired “ideal” emotional environment of each family may be different. Some parents may have never learned how to appropriately express emotions or may have never experienced a parental figure express interest in them, and therefore may request or agree to learn new ways of interacting with their children. Cognitive behavioral techniques may help clinicians offer families techniques and skills to regulate their affect, including topics such as distress tolerance and coping skills to effectively deal with particularly negative emotions (Baucom, Epstein, & LaTaillade, 2002).

5.4 RESEARCH IMPLICATIONS

There are several research implications as a result of this study that should be considered in future work. Firstly, this study should be replicated not only in the present setting but in other settings as well. These settings should include other outpatient centers in both urban and rural areas. Additionally, this study could also be conducted in other levels of care within the mental health field as well, including inpatient hospitals and partial hospitalization programs. This additional information would not only help to establish the validity of the present findings but would also add knowledge to the field and assist the clinical administrators in these various settings (Shadish et al., 2002; Miller, 2007). Additionally, a longitudinal study examining family functioning over time in an outpatient setting would help clinical administrators to determine if the tailored services, based on the functioning of the families as they initiate services, are effective. A longitudinal study would “allow examination of how effects change over time” (Shadish et al., 2002, pp. 266-267). Furthermore, understanding more about the families involved, such as how they were referred to the clinic, may provide significant information that is necessary in effectively tailoring therapeutic services. Given that this is the first study of its kind in the field, the purpose of the present study was explorative and descriptive in nature. Further evaluations attempting to gauge the effectiveness of the tailored services are important next steps in the research process.

Another important future research endeavor will be to incorporate the perspectives of the families by utilizing a mixed methods design. By using tools such as focus groups, families can provide a vivid account of the concerns they endorse on the measurement (Jaccard & Jacoby, 2010). Focus groups may also provide clinical administrators and therapists ideas about how to

tailor services to meet the needs of the clients. This method could then be paired with a longitudinal design examining the effectiveness of these tailored services. The low refusal and attrition rates in this study are clinically significant. Families may be interested in helping clinical administrators to better understand their needs so that their needs may then in turn be met by the services offered.

5.5 LIMITATIONS

There are several important limitations to consider when evaluating this study. One important limitation is the fact that the current study was completed in only one outpatient setting. Findings in other settings, including other outpatient settings in various locations (e.g., other urban communities, rural communities, etc.) as well as other mental health service providers may indicate different findings. However, the purpose of the present study was to explore and describe the family functioning of clients initiating services at a particular outpatient clinic in order to help clinical administrators tailor services to meet the needs of the clients. Thus, although the present study was able to meet the current research objectives, future research in other settings would add knowledge to this field of study.

Another limitation of the present study is research design that was employed. This study included an exploratory and descriptive design aimed at gathering more information in an area of the field that had not previously been examined. The cross sectional nature of the study does not lend itself to studying trends over time or considering cause and effect. Although the present study met the research objectives and answered the research questions posed, future research with various study designs are indicated.

Furthermore, only one assessment was used in the present study to assess family functioning. Although there is strong psychometric support for use of the Family Assessment Device, as it has been described as a “well-established” measure, other instruments should also be considered in future research (Alderfer et al., 2009, p. 1050).

5.6 CONCLUSION

The purpose of the present study was to explore and describe the functioning of families as they initiate outpatient community mental health services in an effort to better understand their needs and ultimately to tailor the services to meet these needs. The results of this study indicate that there are three clusters or groups of families who sought services at a particular outpatient community mental health clinic: 1) families with healthy family functioning on all of the subscales of the FAD, 2) families with unhealthy functioning on all of the subscales, and 3) families with healthy functioning on some of the subscales and unhealthy functioning on the others. For families who obtained both healthy and unhealthy scores on the subscales of the measurement, roles and affective involvement were found to be concerning areas for a majority of families. The areas of communication, roles, and affective involvement were identified as concerning to a majority of families in the study. However, only the area of affective involvement indicated that a large proportion of families experienced difficulties.

Overall, this study suggests that thoroughly assessing family functioning at the initiation of treatment is a crucial step in gathering important information needed to tailor services to meet the needs of the clients initiating services. Furthermore, the areas of roles, communication, and

particularly affective involvement should be considered in the structuring of treatment offered in outpatient community mental health clinics. Assessing for and incorporating these areas of family functioning into treatment are essential in developing family focused and guided treatments.

APPENDIX A

COVER PAGE AND FAMILY ASSESSMENT DEVICE

Research Study Cover Page

Please **DO NOT** write your name or your child's name anywhere on this survey or envelope.

Please respond to the following:

1. Age of your child:
2. Sex of your child: Male Female
3. Race of your child:

Family Assessment Device

Instructions: The following are statements about families. Please read each statement and indicate whether you strongly agree (SA), agree (A), disagree (D) or strongly disagree (SD) with each by circling the choice corresponding to your response.

1. Planning family activities is difficult because we misunderstand each other.
2. We resolve most everyday problems around the house.
3. When someone is upset the others know why.
4. When you ask someone to do something, you have to check that they did it.
5. If someone is in trouble, the others become too involved.

6. In times of crisis we can turn to each other for support.
7. We don't know what to do when an emergency comes up.
8. We sometimes run out of things that we need.
9. We are reluctant to show our affection for each other.
10. We make sure members meet their family responsibilities.
11. We cannot talk to each other about the sadness we feel.
12. We usually act on our decisions regarding problems.
13. You only get the interest of others when something is important to them.
14. You can't tell how a person is feeling from what they are saying.
15. Family tasks don't get spread around enough.
16. Individuals are accepted for what they are.
17. You can easily get away with breaking the rules.
18. People come right out and say things instead of hinting at them.
19. Some of us just don't respond emotionally.
20. We know what to do in an emergency.
21. We avoid discussing our fears and concerns.
22. It is difficult to talk to each other about tender feelings.
23. We have trouble meeting our bills.
24. After our family tries to solve a problem, we usually discuss whether it worked or not.
25. We are too self-centered.
26. We can express feelings to each other.
27. We have no clear expectations about personal hygiene.
28. We do not show our love for each other.

29. We talk to people directly rather than through go-betweens.
30. Each of us has particular duties and responsibilities.
31. There are lots of bad feelings in the family.
32. We have rules about hitting people.
33. We get involved with each other only when something interests us.
34. There's little time to explore personal interests.
35. We often don't say what we mean.
36. We feel accepted for what we are.
37. We show interest in each other when we can get something out of it personally.
38. We resolve most emotional upsets that come up.
39. Tenderness takes second place to other things in our family.
40. We discuss who is to do household jobs.
41. Making decisions is a problem for our family.
42. Our family shows interest in each other only when they can get something out of it.
43. We are frank with each other.
44. We don't hold to any rules or standards.
45. If people are asked to do something, they need reminding.
46. We are able to make decisions about how to solve problems.
47. If the rules are broken, we don't know what to expect.
48. Anything goes in our family.
49. We express tenderness.
50. We confront problems involving feelings.
51. We don't get along well together.

52. We don't talk to each other when we are angry.
53. We are generally dissatisfied with the family.
54. Even though we mean well, we intrude too much into each others lives.
55. There are rules about dangerous situations.
56. We confide in each other.
57. We cry openly.
58. We don't have reasonable transportation.
59. When we don't like what someone has done, we tell them.
60. We try to think of different ways to solve problems.

(Epstein et al., 1983)

APPENDIX B

CLINICIAN SCRIPT

The purpose of this research study is to learn more about the families being served at the Center for Children and Families so that we can improve and tailor the services offered here at the clinic. For this reason, we will be surveying parents and legal guardians who are bringing their children and adolescents to one of their first three sessions of treatment here at CCF. We are asking all parents and legal guardians within the first three sessions of treatment to complete a 60 question survey that will ask questions about their families, such as how their family members communicate and solve problems together. This survey will take approximately 15 minutes to complete. Please also list the age, race, and sex of your child on the survey. This information is being collected for descriptive purposes only and not to identify anyone in your family. There are no foreseeable risks associated with this project, nor are there any direct benefits to you. This is an entirely anonymous questionnaire, and so your responses will not be identifiable in any way. All responses are confidential, and results will be kept under lock and key. Your participation is voluntary.

APPENDIX C

GLOSSARY

Affective Involvement: “The degree to which the family as a whole shows interest in and values the activities and interests of individual family members” (Miller et al., 2000, pp. 171-172).

Affective Responsiveness: “The ability of the family to respond to a range of stimuli with the appropriate quality and quantity of feelings” (Miller et al., 2000, p. 171).

Analysis of Variance: A statistical technique that “is used to evaluate mean differences between two or more treatments (or populations)” (Gravetter & Wallnau, 2007, p. 389).

Attrition: “Loss of units” or participants in a study (Shadish et al., 2002, p. 505).

Behavior Control: The behavior of family members in three situations including dangerous situations, situations in which psychobiological needs are expressed, and situations that involve interpersonal and social behaviors (Miller et al., 2000).

Brief Treatment: A therapeutic model that focuses on time-limited interventions, clearly described and client directed goals, and finding solutions to listed problems (Gladding, 2002).

Case Study: The analysis or study of a single case, such as an individual or family, in great detail (Jaccard & Jacoby, 2010).

Circular Causality: The belief that events are interrelated; one cause does not lead to one effect (Gladding, 2002; Flaskas, 2010).

Cluster: “Categories into which actual phenomenon...fit to a greater or lesser extent” (Julnes, 2000, p. 543).

Cluster Analysis: A statistical technique that “seeks to identify...categories into which phenomenon can be placed” (Julnes, 2008, p. 543).

Cognitive Behavioral Therapy: A therapeutic model that incorporates the effect that cognitions (i.e., thoughts) and behaviors (i.e., actions) have on one's emotional state. Goals of the approach including altering thoughts and behaviors to change the emotional state (Gladding, 2002).

Communication: "How information is exchanged within a family" (Miller et al., 2000, p. 170).

Communication Apprehension: Fear of communication with others (Hsu, 1998).

Communication Avoidance: "The unwillingness to communicate" (Avtgis, 1999, p. 334).

Concurrent Validity: Validity of a measure in which the measure "correlates with some contemporaneous external criterion" (Miller, 2007, p. 72).

Conflict Avoidance: A family's decision to suppress conflict or disagreement versus choosing to openly express differences in opinions (Schrodt, 2005).

Conformity Oriented: The support of authority (e.g., parental authority, societal pressures) in families (Huang, 1999).

Conversation Oriented: Characterized by families who support open communication, including discussions that incorporate disagreement (Huang, 1999).

Correlational Study: "A study that observes relationships among variables" (Shadish et al., 2002, p. 506).

Cross-Sectional: A study design in which all of the data are collected at one time point (Shadish et al., 2002).

Desirability of Control: Having certain personality traits such as assertiveness and decisiveness (Huang, 1999).

Discriminant Validity: "The notion that a measure of A can be discriminated from a measure of B, when B is thought to be different from A" (Shadish et al., 2002, p. 507).

Effect Size: A number ranging from 0 to 1, often used in research as "an overall measure of the magnitude of the effect" (Keppel & Wickens, 2004, p. 152).

Engagement: A term used in the field of family therapy that represents the positive working relationship developed between the therapist and the family, usually within the first several sessions of treatment (Berg, 1994).

Ethnography: “A broad class of qualitative methods applied with the purpose of providing a detailed, in-depth description of everyday life and practice” (Jaccard & Jacoby, 2010, p. 261).

Family Cohesion: “How family members balance the importance of independence with the mutuality of being a member of a family system” (Smith et al., 2009, p. 80).

Family Flexibility: “How family systems balance stability versus change” (Smith et al., 2009, p. 80).

Family Functioning: The quality of the relationship between family members, including the degree to which family members feel close to one another and the level of conflict present between family members (Thompson et al., 2007).

Family Therapy: A therapeutic model that incorporates all related (biologically and psychologically related) individuals into the treatment. Individual symptoms are viewed within this family context versus individual etiology (Gladding, 2002).

Feminist Theory in Mental Health: A theoretical perspective that encourages gender equality in therapeutic practices as well as society and acknowledges the relationship between sexism in society and the increased risk of experiencing mental health concerns (Gladding, 2002).

Generalizability: This occurs when the sample represents the population and the results can then be applied from the study to the target population (Miller, 2007).

Grounded Theory: “The approach of letting theory emerge from data rather than using data to test theory” (Scharer & Jones, 2004, p. 256).

Internal Consistency: The “consistency of response across different items of a single test given at a single time” (Miller, 2007, p. 73).

Interpersonal Cognitive Problem Solving Skills: “A constellation of skills that includes the ability to identify problems, the capacity to generate alternative solutions to problems, and the ability to specify a viable course of action after evaluating the consequences of the possible alternate courses of action” (Kennedy et al., 1988, p. 74).

Kinship Care: A foster care arrangement in which the child is placed with family members (Green & Goodman, 2010).

Linear Causality: The belief that one cause leads to one effect (Gladding, 2002; Flaskas, 2010).

Longitudinal Study: A study in which the data are collected over a period of time versus all at once (Shadish et al., 2002).

Managed Care: A third party payer; insurance company (Gladding, 2002).

McMaster Family Assessment Device: A 60 item self report measure that assesses family functioning in the following areas: communication, problem solving, roles, affective involvement, affective responsiveness, and behavior control (Epstein et al., 1983; Miller et al., 2000).

Measurement Attrition: “The failure to obtain all of the necessary information or responses from participants in the study” (Shadish et al., 2002, p. 509).

Mediator: “A third variable that comes between a cause and effect and that transmits the causal influence from the cause to the effect” (Shadish et al., 2002, p. 509).

Multi-Informant Method: A method of collecting data in which multiple individuals are asked to report on the variable of interest (Shadish et al., 2002).

Multiple Imputation: A statistical technique for dealing with missing data. The technique estimates a distribution for each participant based upon a available data. From each individual participant’s distribution, multiple complete datasets are generated. Missing values are randomly drawn from the datasets and estimates from each dataset are pooled (Acock, 2005; Tabachnick & Fidell, 2007).

Narrative Therapy: A therapeutic model in which therapists attempt to understand their clients’ view or narrative of the world (Flaskas, 2002; White & Epston, 1990).

Outcomes Research: Research that “seeks to understand the end results of particular health care practices and interventions” (U.S. Department of Health and Human Services, 2000, para. 1).

Predictive Validity: “A test that correlates with some future external criterion” or the ability to predict future outcomes (Miller, 2007, p. 72).

Problem: “An issue for which the family has trouble finding a solution, and the presence of which threatens the integrity...of the family” (Miller et al., 2000, p. 170).

Problem Solving: The ability to “resolve problems at a level that maintains effective family functioning” (Miller et al., 2000, p. 170).

Psychoeducation: A cognitive behavioral technique that incorporates educational materials (e.g., books, videos, case examples) into treatment (Gladding, 2002).

Regression Analysis: A statistical technique that tests the prediction of variables (Gravetter & Wallnau, 2007).

Reliability: The “consistency” of results (Shadish et al., 2002, p. 511).

Representativeness: Occurs when the sample corresponds to or characterizes the population (Miller, 2007).

Reticence: When individuals avoid communication with others out of fear of appearing ridiculous (Kelly et al., 2002).

Ritual: “A symbolic form of communication that is enacted systematically and repeatedly over time and which holds special meaning for family members” (Baxter & Clark, 1996, p. 254).

Roles: “Recurrent patterns of behavior by which individuals fulfill family functions” (Miller et al., 2000, p. 171).

Self-Disclosure: The extent to which one shares personal information with others (Huang, 1999).

Self-Esteem: One’s self-judgment or evaluation of self-worth (Huang, 1999).

Self-Monitoring: The ability to monitor behavior to meet social requirements (Huang, 1999).

Semi-Structured Interviews: Interviews or conversations in which a general purpose and outline of the interview is prepared. However, the course of the interview can change based upon the participant’s responses (Pawson & Tilley, 1997).

Social Constructionism: The perspective that “holds that reality is a construction of the human mind” (Jaccard & Jacoby, 2010, p. 9).

Social Desirability: The way in which an individual expresses oneself in public to maintain social approval (Huang, 1999).

Structural Family Therapy: A model of family therapy that asserts that in order for symptoms to be reduced, changes in the family’s structure or balance must first occur (Gladding, 2002).

Structural Traditionalism: The extent to which families meet expectations set by external authority figures, including society (Schrodt, 2005).

System: “An organized entity whose interrelated elements interact with one another so as to achieve some common goal” (Jaccard & Jaccoby, 2010, p. 310).

Systematic Attrition Bias: “Loss of respondents to treatment or to measurement can produce artificial effects if that loss is systematically correlated with conditions” (Shadish et al., 2002, p. 55).

Systems Theory: The theoretical perspective that asserts that “a system is a set of elements standing in interaction with one another. Each element in the system is affected by whatever happens to any other element” (Gladding, 2002, p. 68).

Test-Retest Reliability: High consistency in results among two (or more) occasions of administering a measure (Miller, 2007).

Typology: A conceptual model, made up of clusters, that assists in the understanding of particular phenomena (Julnes, 2000).

Validity: “The truth of, correctness of, or degree of support for an inference” (Shadish et al., 2002, p. 513).

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