

**IS FAMILY THERAPY EFFECTIVE, ACCEPTABLE, AND SUSTAINABLE
FOR MOTHERS AND CHILDREN?: AN EXAMINATION OF STRUCTURAL
FAMILY THERAPY IMPLEMENTED WITHIN A SEMI-RURAL COMMUNITY
MENTAL HEALTH SETTING**

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The gap between knowledge about psychotherapy generated in laboratory settings and its application in routine treatment settings prevents consumers from receiving state-of-the-art, evidence-based care, prolongs their suffering, and underutilizes the economic resources supporting efficacy trials. Family therapy has strong evidence for treating children's behavioral health needs, yet few studies have examined its effectiveness in the real world. Further, family therapy provides an opportunity to address the demonstrated link between maternal and child mental health symptomatology in a way likely to engage untreated mothers and their presenting children. However, only one study has examined the impact of family therapy on maternal mental health symptomatology and very few address maternal functioning.

This mixed methods study examined the effectiveness, acceptability, and sustainability of Structural Family Therapy for mothers and their presenting children seeking care at a semi-rural community mental health clinic. Results suggest some support for the effectiveness of family therapy. Mothers' mental health symptomatology and mothers' ratings of children's impairment improved with time spent in family therapy; however, mothers' self-ratings of their functioning and children's ratings of their own mental health symptomatology did not change. Results also suggest that mothers found family therapy acceptable, as they reported gaining skills to more effectively

manage their children's behavioral challenges as well as strategies for their own self-care. In addition, mothers' perceptions of family treatment glean insight to its sustainability in routine settings. Language used by mothers suggests that therapists adhered to core aspects of the Structural Family Therapy model. However, mothers indicated their children's severe behavioral challenges and the inconsistency of treatment sessions influenced their treatment outcomes.

Findings from this study suggest that family therapy may provide an innovative, empirically supported approach to engage and treat mothers with mental health needs whose children present for community treatment. Additionally, findings from this study offer insight to implementation challenges within this real world setting that may have impacted children's outcomes. Results of this study provide a number of implications for social work practice and suggestions for future research.

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*for Nora,
my motivation, inspiration, and greatest accomplishment*

1.0 INTRODUCTION

1.1 PURPOSE OF THE STUDY

Consumers treated in routine outpatient mental health settings are unlikely to receive evidenced-based care (e.g. Bickman, 1996; Nathan, Stuart, Dolan, 2000; Panzano & Herman, 2005; Rotheram-Borus & Duan, 2003; Torrey & Gorman, 2005). Rural consumers are even less likely to receive guideline concordant care of any kind than their urban and suburban counterparts (Wang et al., 2005). When mental health consumers do not receive evidence-based care, their own individual functioning as well as their family's well being, is compromised (Proctor, 2004). Consumers seeking care in routine settings often experience multiple challenges, such as co-occurring disorders and low-income status, that affect not only the identified patient, but the entire family (Segal, Hardiman & Hodges, 2002). Family therapy, based on a systemic orientation, offers an empirically supported intervention that is likely to benefit consumers seeking routine mental health treatment and their families. However, to date, family treatment has primarily been tested in laboratory or university settings, with little work examining its effect in routine practice settings (Carr, 2000; Hunsley & Lee, 2007; Shadish et al., 1993; Shadish & Baldwin, 2003).

Family therapy provides a particularly useful approach to address the intimately intertwined relationship between maternal and child mental health. While scholarship consistently demonstrates high levels of unmet mental health needs among mothers

initiating mental health treatment for their children, it has been particularly challenging to engage these mothers in treatment (Anderson et al., 2006; Ferro, Verdeli, Pierre & Weissman, 2000; Kaufman et al., 1998; Rishel, Greeno, Marcus, & Anderson 2006a; Rishel, Greeno, Marcus, Sales, Shear, Swartz & Anderson, 2006b; Swartz, Shear, Wren, Greeno, Sales & Sullivan et al., 2005). Offering concurrent care for both mothers and their children is likely to improve outcomes for both family members and appears to align with mothers' views of treatment (Anderson et al., 2006; Nicholson et al., 1998). Meta-analytic reviews present strong evidence for the efficacy of family therapy on a variety of child behavior health outcomes (Carr, 2000a; Shadish, Montgomery & Wilson et al., 1993; Shadish, Ragsdale, Glaser & Montgomery, 1995). Though systemic family therapy, rooted in general systems theory, posits that mothers will be impacted by the intervention for the same reasons children are, studies largely ignored its effect on mothers' mental health symptomatology or functioning (Carr, 200b).

This dissertation research made use of a unique opportunity to analyze pilot data on the effects of family therapy, adapted in situ for a semi-rural community mental health agency. This work utilized a mixed methods approach to examine the effectiveness, acceptability, and sustainability of Structural Family Therapy for addressing mental health symptomatology of mothers and their presenting children, maternal functioning, and treatment satisfaction within a real world treatment setting. Of 54 families recruited, 31 met dose eligibility inclusion criteria and comprised the sample for this analysis. Outcomes for mothers' mental health symptomatology, maternal functioning, children's mental health symptomatology, and treatment satisfaction were measured at three equal intervals over the six-month study period (baseline, 3 months, and 6 months). Mothers

also completed semi-structured, engagement focused interviews about treatment for their children and themselves. This work analyzed the standardized scales for change over time and analyzed the interviews for themes regarding mental health treatment for mothers and their reactions to Structural Family Therapy.

1.2 BACKGROUND AND SIGNIFICANCE

1.2.1 The Need for Effectiveness Research in Routine Mental Health Settings

While a large body of intervention research, accumulated over more than 40 years, has convincingly demonstrated the general efficacy of psychotherapy (Lambert & Bergen, 1994), these research findings have had little impact on everyday clinical practice (Kopta, Lueger, Saunders, & Howard, 1999; Nathan, Stuart & Dolan, 2000). The gap between what is known about efficacious treatment and what is provided to consumers in routine, community practice settings has been identified as one of most critical issues in mental health services research (Proctor, Landsverk, Aarons, Chambers, Glisson & Mittman, 2009). In fact, there is an estimated 20-year gap between knowledge generated from the best efficacy research and the utilization of that knowledge in routine mental health care (DHHS, 1999; Institute of Medicine, 2000; New Freedom Commission on Mental Health, 2003). This gap prevents Americans living with mental health needs from reaping benefits of billions of tax dollars spent on research and, more important, prolongs their suffering (New Freedom Commission on Mental Health, 2003).

Social workers are uniquely poised to address this gap, which has been of concern throughout social work's modern history (Hess & Mullen, 1995; Kirk & Reid, 2002); however relatively few social work scholars are engaged in mental health services research (Austin, 1999) and few effectiveness studies have been published by social work researchers (Brekke, Ell & Palinkas, 2007). Social workers have both clinical and research skills, a valuable combination in this field. The profession's history of community partnerships and more recent focus on the acceptability of the evidence-based practice process, combined with training that emphasizes the importance of local

knowledge and the need to tailor treatment for diverse practice settings, creates a natural opportunity for social work scholars to engage in effectiveness research (Proctor & Rosen, 2008; Strickler & Trierweiler, 1995). It is imperative that social workers answer this call as consumers who are affected by the gap between research and practice constitute a vulnerable population unable to benefit from known efficacious treatments.

Consumers seeking routine outpatient mental health services experience a high level of need, in part due to high rates of co-occurring disorders, the tendency to seek care later in the disease process, and low-income status (Segal et al., 2002). However, interventions with proven efficacy are much less likely to be implemented in community settings than value-driven models that lack scientific evidence (Bickman, 1996; Rotheram-Borus & Duan, 2003). This is especially true in rural areas, where consumers are less likely than their urban and suburban counterparts to receive guideline concordant care (Wang et al., 2005).

Limited research has examined the effectiveness of empirically supported interventions in community settings (Hunsley & Lee, 2007). This in part reflects the qualitatively different characteristics of community mental health settings when compared to the controlled laboratory and university settings selected for efficacy trials. For example, efficacy research often establishes stringent inclusion criteria that prevent an estimated two-thirds of referred consumers from study participation (Westen & Morrison, 2001) and utilizes manualized treatment protocols, often requiring 13 to 18 weekly therapy sessions to demonstrate improvement (Hansen, Lambert & Forman, 2002). These conditions are not feasible in routine practice settings where between 25 and 50 percent of consumers drop-out of psychotherapy by not returning after the initial

assessment or first therapy session (Garfield, 1994; Merrill, Tolbert & Wade, 2003) and those that do continue attend an average of 4.3 therapy sessions (Hansen et al., 2002). While the importance of implementing empirically supported treatments in real world settings has gained greater attention recently, as evidenced by the National Institute of Mental Health's prioritization of translational science (DHHS, 2006), only a small number of interventions have actually been tested in the community. A recent review identified a total of 35 effectiveness studies conducted for both adult (n=21) and child treatments (n=14), all but one of which was published in the last decade (Hunsley & Lee, 2007). Further work testing empirically supported psychotherapies within routine practice settings is necessary to ensure consumers receive state-of-the art, evidence-based care that is both effective and acceptable.

1.2.2 Structural Family Therapy

Structural Family Therapy (SFT) is a pragmatic, short-term approach designed to address family relationship problems, often reflected through presenting individuals' behavioral health needs. Salvador Minuchin and colleagues created SFT to accommodate the issues of low-income, multi-problem families like those often seen in routine outpatient mental health settings (Minuchin, 1974; Minuchin & Fishman, 1982; Minuchin, Colapinto & Minuchin, 2007). The SFT model, rooted in the Interpersonal Theory of Psychiatry and Family Systems Theory, is guided by two primary principles: 1) a view of the family as the primary social context of its members and 2) a systemic orientation, positing the action of one family member impacts the entire family system (Sullivan, 1953; Bateson, 1972; Carr, 2006; Minuchin, 1974). SFT utilizes principles

from both theoretical traditions in order to provide a basic, yet robust treatment approach that can be easily trained, and administered by paraprofessionals.

The SFT model contends that presenting symptoms or behavior problems experienced by one member of the family system can be understood as stemming from the family's underlying patterns of transactions and that these transactions are governed by a clear set of hierarchical organizing principles (Minuchin, 1974). The Structural approach maintains that healthy families are characterized by distinct subsystems with clear boundaries. However, the boundaries cannot be so rigid that natural adaptation necessary as families move through the life course cannot occur. SFT asserts that families adopt dysfunctional patterns when generational boundaries are not maintained or when a family's stress exceeds their ability to adapt. However, this approach posits that these dysfunctional patterns can be moved towards healthier structures through therapy (Minuchin, 1974; Minuchin & Fishman, 1982; Colapinto, 1982).

The core elements of Structural Family Therapy are well standardized. Further, the Structural model's central tenets have been incorporated into efficacious family approaches, including Brief Strategic Family Therapy, Multidimensional Family Therapy and Multisystemic Therapy, which have been adopted as best practices. Systematic reviews consistently demonstrate the efficacy of family treatment in general for treating a variety of child behavioral health needs (Shadish et al., 1993; Shadish et al., 2003; Carr, 2001), including general conduct disorder, aggression, global psychiatric symptoms, schizophrenic symptoms, and communication and problem solving skills (Shadish et al., 1993). Though meta-analytic reviews suggest that systemically oriented family therapy, like SFT, has a statistically significant effect for treating child outcomes ($d = .25$),

specifically child and adolescent conduct disorders ($d = .26$). Models of systemic family therapy share the theoretical underpinnings of general systems theory and have been found to result in better outcomes when compared to wait list controls and have proven to be as efficacious as behavioral family therapy (Shadish et al., 1993; Shadish et al., 1995).

However, like most empirically supported treatments, family therapy has been almost exclusively tested in laboratory or university settings, on children who do not generally represent community mental health consumers (Burns, Hoagwood, & Mrazek, 1999; Shadish & Baldwin, 2003). Further, even fewer studies examine the impact of family therapy on parental outcomes (Liddle et al., 2002; Schuhmann et al., 1988), with only one identified study examining its effect on maternal mental health symptomatology (Barkley et al., 1992). While existing scholarship has not tested SFT in routine practice settings, its systemic theoretical underpinnings suggest utility, with particular relevance to addressing the known link between maternal and child mental health needs.

1.2.3 The Link Between Maternal and Child Mental Health Needs

Mothers' and children's mental health needs are intimately intertwined (e.g. Diaz-Caneja & Johnson, 2004; Lyons-Ruth, Wolfe, Lyubchik & Steingard, 2003). Mental health needs are common among both mothers and children, with approximately one-fourth of mothers meeting criteria for lifetime prevalence of depression and one-third meeting the same criteria for anxiety disorders (Nichols, Sweeney & Geller, 2002) and as many as one in five children and adolescents meeting criteria for an Axis-I psychiatric disorder (Shaffer, Fisher, Dulcan & Davies, 1996; DHHS, 1999), and negatively impact one another. Empirical work consistently demonstrates the negative impact of maternal depression on a variety of children's clinical, behavioral, and social outcomes (Beardslee,

Bemporad, Keller & Klerman, 1988; Coiro, 2001; Downey & Coyne, 1990; Goodman & Gotlib, 1999; Mowbray et al., 2001; Weissman et al., 1997; Weissman et al., 2004).

Additionally, mothers' mental health needs have been associated with their children's poor behavioral health treatment outcomes, specifically less treatment adherence and recurrence of illness (Dover et al., 1994; Kaufman et al., 1998; Rishel et al., 2006a). A limited, but equally consistent body of work suggests that children's behavioral health status impacts mothers as well. Findings indicate that the presence of children with behavioral challenges disrupts family relationships and is associated with increased parental distress and caregiver burden (Kovacs et al., 1997; Oyserman et al., 2005; Puig-Antich et al., 1989).

This reciprocal relationship creates a negatively reinforcing cycle. For example, mothers' mental health symptomatology can contribute to parenting behavior that is either too intrusive or withdrawn, which may trigger disruptive outbursts in children, which mothers may have difficulty managing, therefore exacerbating the child's behavior and the mothers' symptomatology. Mothers with mental health needs who are also caring for children experiencing behavioral health difficulties find it challenging to juggle the needs of multiple affected family members (Nicholson et al., 1998; Lyons-Ruth et al., 2003). This often results in mothers' putting their own care behind their children's needs.

A series of studies utilizing bottom up sampling strategies demonstrate a high level of unmet need among mothers whose children present for mental health treatment. The literature suggests that more than 60% of these mothers met diagnostic criteria for depression or anxiety (Ferro et al., 2000; Nicholson et al., 1998; Kaufman et al., 1998; Rishel et al., 2006a; Rishel et al., 2006b; Swartz et al., 2005); however less than one-third

were receiving services or accepted referrals for individual treatment (Anderson et al., 2006; Swartz et al., 2005). This finding was consistent among mothers initiating treatment for their children within a rural routine practice setting (Swartz et al., 2005); and, in fact, nationally representative data reveal that mothers living in rural areas and low-income mothers are at an increased risk for experiencing high levels of depressive symptomatology (Huang et al., 2007), yet are less likely to seek treatment than their respective urban and higher income counterparts (Kessler et al., 1994; Wang et al., 2005).

Qualitative work exploring why mothers whose children present for community mental health treatment don't seek care for their own needs, suggests that individual treatment may not be acceptable (Anderson et al. 2006; Nicholson et al., 1998). Mothers reported feeling as if individual treatment was too risky, as they feared a mental health diagnosis could result in being labeled an unfit mother. Mothers also reported feeling that individual treatment was not necessary, believing their own symptomatology was caused by their children's behavioral health needs. However, mothers reported a desire for increased involvement in their children's treatment (Anderson et al., 2006).

The literature suggests that despite the known link between maternal and child mental health that subsequently creates a negatively reinforcing cycle, mothers' mental health needs remain unaddressed and impairments remain in maternal functioning and parenting skills, leading to the continuation of poor maternal and child outcomes (Swartz et al., 2008). Evidence also indicates that mothers living in rural areas and low-income mothers and their families require increased attention from mental health services researchers. Structural Family Therapy is an empirically supported intervention with great potential for concurrently addressing the systemic nature of mothers' and children's

mental health needs in a way that is likely acceptable to mothers. However, very few studies have examined the impact of family therapy on maternal functioning and only one identified study has addressed its impact on mothers' mental health symptomatology (Barkey et al., 1992; Liddle et al., 2002; Schuhmann et al., 1988).

1.3 RESEARCH QUESTIONS & HYPOTHESES

This study examines three research questions. Together, these questions offer a comprehensive assessment of Structural Family Therapy's effectiveness, acceptability, and sustainability for treating mothers and their presenting children in a semi-rural community mental health setting. The first two questions, addressing effectiveness, will be examined quantitatively while the second question, addressing acceptability and sustainability, will be explored qualitatively through semi-structured interviews. Descriptive analysis of treatment satisfaction measures will be integrated with the qualitative interviews to gain a more comprehensive understanding of mothers' perceptions of the acceptability and sustainability of family therapy.

Q-1) Does mothers' mental health symptomatology (depressive symptomatology and anxiety) and functioning change with time spent in Structural Family Therapy?

H-1: Mothers receiving Structural Family Therapy will demonstrate improvement of mental health symptomatology (depressive symptomatology and anxiety) and functioning with time spent in treatment.

Q-2) Does children's mental health symptomatology (depressive symptomatology and general impairment) change with time spent in Structural Family Therapy?

H-2: Children receiving Structural Family Therapy will demonstrate improvement of mental health symptomatology (depressive symptomatology and general impairment) with time spent in

treatment.

Q-3) What are mothers' perceptions of treatment for their own needs and of family therapy?

1.4 SIGNIFICANCE TO SOCIAL WORK PRACTICE AND RESEARCH

This study makes a number of significant contributions to the areas of social work practice, mental health services and intervention research, and knowledge development that aim to improve the lives of families, especially mothers and their children, utilizing community mental health settings. First, this study tests an empirically supported intervention within a community mental health setting, contributing to a translational research agenda and using scientific evidence to tangibly impact a routine practice setting that typically serves vulnerable populations. Developing a greater understanding of evidence-based care that is effective and acceptable in community mental health settings enhances public health in general and improves mental health service delivery for consumers in community mental health settings (Proctor et al., 2009). The fact that this work was conducted within a semi-rural mental health setting is of increased importance, as rural populations have historically been understudied, if not ignored, by mental health services researchers (Mulder et al., 2001).

Second, this study contributes to strengthening the mental health services research agenda within the profession of social work. Social work is dramatically underrepresented among those trained for mental health services research careers (Austin, 1999; DHHS, 2003). While there has been an increased focus on evidence-based practice and the evidence-based practice process among social work researchers and educators, there is virtually no social work literature on how to implement evidence-based practice in routine practice settings or research that assesses its effectiveness when implemented in the “real world” (Brekke et al., 2007). Consequently, thus far, evidence-based practice has had little tangible impact on social work and has not been routinely implemented in

practice (Addis, 2002; Addis & Krasnow, 2000; Mullen & Bacon, 2003; Rosen, 1994; Rosen et al., 1995).

This is of even greater relevance when considering that social workers provide the majority of mental health services in the United States (Occupational Outlook Handbook, 2206-2007, 2006; O'Neill, 1999, June). Findings from this study will inform and influence social work practitioners and administrators in mental health settings who decide which interventions best meet consumers' needs. As a result, they are in a position to impact the health and wellbeing of a large number of consumers. A greater understanding of treatments that are effective and acceptable allows social workers to enhance their tool kit and tailor treatment based upon consumers' specific needs. Not only do social workers engage in direct practice, they also administer the majority of social service programs in the country and therefore are responsible for policies that affect hundreds of thousands of consumers (O'Neill, 1999, June). In that capacity, they decide which interventions to deliver and subsequently impact whether individuals and families receive effective, appropriate treatments. The current study increases administrators' understanding about family therapy's utility within the community mental health setting, as well as in rural settings, and provides insight to an intervention with the potential to ensure that both mothers and children receive effective, acceptable, and sustainable mental health services.

Further, finding and treating mothers with mental health needs whose children present for community mental health treatment has important implications for public mental health services. The National Association of Social Worker's policy on mental health (2005) argues that social workers should pursue knowledge building in the area of

mental health access. This study directly addresses this call by examining the acceptability of family therapy for a hard to reach population of mothers who are balancing their children's behavioral health needs with their own unmet mental health needs. Identifying acceptable interventions ultimately impacts engagement and access, as consumers are more likely to follow through with treatment if it meets their needs.

1.5 SUMMARY

Most empirically supported treatments, including family therapy, have not been tested in routine practice settings (Shadish et al., 1995; Weisz, Weiss & Donenberg, 2002), and subsequently have had little impact on real world mental health service delivery system. This is of particular relevance to social work, as these consumers are among the most vulnerable, often living with complex problems affecting multiple family members as well as limited financial resources (Proctor et al., 2009; Segal et al., 2007).

Structural Family Therapy (SFT) offers an empirically supported intervention with great promise for addressing the complex needs of families seeking routine mental health treatment, including the known link between maternal and child mental health needs. SFT was specifically designed to meet the needs of multi-problem, low-income families (Minuchin, 1974). The basic, yet robust principles of this family model make it easy to train and are consistent with community mental health consumers' preference for short-term, pragmatic approaches. Further, SFT has a systemic orientation that focuses on restructuring dysfunctional patterns of transaction and reestablishing the family's organizational hierarchy. This focus aligns with mothers' views of their mental health needs as being related to their children's needs and is likely an acceptable way to engage this elusive population.

Evidence suggests that systemic family therapy, such as Structural Family Therapy is effective for addressing a variety of child behavioral needs, including conduct disorders and attention problems (Barkley et al., 1992; Shadish et al, 1993; Szapocznik et al., 1989); though SFT has not been tested on children presenting for treatment in real world practice settings. While the underlying systems approach maintains that mothers

would benefit from family therapy for the same reasons children benefit, few studies have examined its impact on maternal functioning (Liddle et al., 2002; Schuhmann et al., 1988) and only one study explored its utility for addressing mothers' mental health symptomatology (Barkley et al., 1992).

This mixed methods pilot study examines the effectiveness, acceptability, and sustainability of Structural Family Therapy for mothers and their presenting children seeking care within a semi-rural community mental health setting. Outcomes for mothers' mental health symptomatology, maternal functioning, children's mental health symptomatology, and treatment satisfaction were measured at three equal intervals over six months for 31 mothers and children who met inclusion criteria. Mothers also completed semi-structured, engagement-focused interviews assessing their perceptions of mental health treatment and family therapy.

2.0 REVIEW OF THE LITERATURE

Although there is a growing body of evidence documenting the efficacy of family therapy for addressing child behavioral health concerns, few studies have explored the effectiveness of family treatment in routine practice settings. In addition, despite the known link between maternal and child mental health treatment needs and the negatively reinforcing cycle that ensues if both family members do not obtain appropriate, effective treatment, even fewer studies have examined the impact of family therapy on mothers' mental health symptomatology and function (Barkley et al., 1992; Liddle et al., 2002; Schuhmann et al., 1998). Further, little work has elicited mothers' perceptions of their mental health treatment needs or their thoughts about specific treatment modalities (Anderson et al., 2006; Nicholson et al., 1998). The semi-rural setting of this work brings added relevance as rural consumers are not likely to receive evidence-based care and rural mothers have been shown to have even greater unmet mental health needs than urban and suburban mothers (Huang et al., 2007; Wang et al., 2005).

This chapter begins with a discussion of the knowledge gap between what is known about the efficacy of psychotherapy and the care received in routine practice settings. Special attention is paid to establishing the need for effectiveness research, highlighting its challenges as well as strategies for success. This chapter continues with an introduction to Structural Family Therapy (SFT), identified as an appropriate, empirically

supported intervention for routine practice settings. The SFT model is presented, followed by its theoretical underpinnings, and finally, evidence supporting family treatment. Next, the reciprocal relationship between maternal and child mental health needs is discussed, with focused attention to the high levels of unmet mental health needs among mothers whose children present for community mental health treatment. The chapter concludes with a synthesis of the information reviewed and presents the rationale for SFT as an effective, acceptable way to concurrently address mothers' and children's mental health needs within the community mental health setting.

2.1 THE STATE OF EMPIRICALLY SUPPORTED TREATMENT IN ROUTINE MENTAL HEALTH PRACTICE SETTINGS

Despite a growing number of empirically supported psychotherapies tested within laboratory and university settings, there is little evidence that these research findings have impacted everyday clinical practice (Bernfield et al., 2001; Kopta, Lueger, Saunders & Howard, 1999; Nathan, Stuart & Dolan, 2000). The gap between what is known about efficacious treatment and the actual use of empirically supported treatment in routine practice settings remains wide and persistent (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Gonzalez, Ringeisen, & Chambers, 2002; Panzano & Herman, 2005; Torrey & Gorman, 2005), compromising consumers' quality of care and threatening clinicians' abilities to reduce health disparities and address family well-being and individual functioning in society (Proctor, 2004). Further, this gap prevents the nation from benefiting from the billions of United States tax dollars spent on research and, of greater importance, prolongs the suffering of millions of Americans living with mental health needs (New Freedom Commission on Mental Health, 2003).

There is an estimated 20-year knowledge gap between our best efficacy research and the utilization of that research in routine mental health service settings (DHHS, 1999; Institute of Medicine, 2000; New Freedom Commission on Mental Health, 2003). This knowledge gap has been identified as one of the most critical issues in mental health services research and has been a great concern throughout social work's modern history (Hess & Mullen, 1995; Kirk & Reid, 2002; Proctor, date), leading to questions over the ability of clinical trials to inform practice in a meaningful way and calls for studies on the

effectiveness of psychotherapy (Howard et al., 1996; Klein & Smith, 1999; Kopta et al., 1999; Norquist, Lebowitz & Hyman, 1999; Seligman, 1995; 1996).

While efficacy studies for psychotherapy have amassed vast amounts of data over the last 40 years (Lambert & Bergin, 1994), most empirically supported treatments, including family therapy, have not been tested in routine practice settings (Drake et al., 2001; Shadish et al., 1995; Weisz, Weiss & Donenberg, 1992). A 2007 review identified only 35 effectiveness studies in total, with 21 studies testing interventions for adults and 14 studies examining interventions for children and adolescents (Hunsley & Lee, 2007). The majority of effectiveness studies addressing adult depression and anxiety, as well as child and adolescent depression, examined models of Cognitive Therapy. In fact, seven of the eight effectiveness studies addressing adult depression and anxiety and two of the three child and adolescent studies addressing depression tested models of Cognitive Therapy (Artanz, 2003; Cahill, Barkham, Hardy, Rees, Shapiro & Stiles et al., 2003; Hardy, Cahill, Stiles, Ispan, Macaskill, & Barkham, 2005; Durham, Fisher, Dow, Sharp, Power, Swan et al., 2004; Merrill, Tolbert & Wade, 2003; Persons, Bostrom & Bertagnoli, 1999; Peterson & Halstead, 1998; Rohde, Clarke, Mac, Jorgenson & Seeley, 2004; Treatment for Adolescents with Depression Study, 2004). However, three of the six studies addressing child and adolescent conduct disorders examined Multisystemic Therapy, a systemic, family-based intervention for youth involved in the juvenile justice system, within community settings (Ogden & Halliday-Boykins, 2004; Rowland et al., 2005; Schoenwald et al., 2005). All three utilized 100% referred samples rather than recruiting children and adolescents presenting for treatment. This limits these studies generalizability to routine practice settings as participants were recruited from a

population that is likely not representative of children and adolescents typically initiating services within routine practice settings. The need for effectiveness research remains evident, though characteristics of routine practice settings present challenges that may discourage researchers from engaging in this important work.

2.1.1 Efficacy v. Effectiveness: Challenges and Strategies for the “Real World”

Efforts to promote translational science and conduct effectiveness research are essential to enhancing public health and improving mental health services for consumers in routine practice settings (Brekke et al., 2007); however, moving from controlled efficacy trials to “real world” practice settings presents complexities and challenges that may deter work in this area. Conducting effectiveness research requires an understanding of routine practice settings, which are qualitatively different from the highly controlled conditions found in laboratory and university environments. The following section outlines key differences between these settings that present challenges for researchers and then identifies agency-university collaboration as a key strategy for the successful implementation of empirically supported treatment in routine practice settings.

Efficacy v. Effectiveness. Intervention research has almost exclusively focused on demonstrating the efficacy of psychotherapy. When establishing efficacy, researchers submit to the most rigorous test of their basic clinical hypotheses under highly controlled conditions (Proctor & Rosen, 2008). The vast majority of efficacy studies utilize Randomized Controlled Trials (RCTs), setting stringent inclusion criteria and ensuring optimal treatment conditions. Typically two RCTs conducted by different researchers, both indicating a psychotherapy’s positive impact on consumer outcomes, are required to establish empirical support for an intervention (Chambless, et al. 1996; Chambless et al.,

1998; Roth & Fonagy, 2004). Efficacy studies are critically necessary, but only one phase of intervention research (Proctor et al., 2009). Clinical trials used to establish efficacy face criticism for trading external validity for internal validity and some researchers and clinicians question the relevance of clinical trials to inform practice across different client populations and service settings (Howard, et al., 1996; Seligman, 1996; Wampold, 1997; Proctor et al., 2009).

Efficacy studies must be followed with effectiveness research in which interventions are tested under conditions reflective of the practice settings in which they are likely to be implemented (Chambless & Hollon, 1998; Goldfried & Wolfe, 1998; Proctor et al., 2009). When conducting effectiveness studies, it is generally not possible to obtain the highly controlled conditions typical in efficacy research that largely ignore attributes of practice context or consider them nuisance variables (Hoagwood et al., 2001; Shadish et al., 2000; Weisz, Donenberg, Han & Weiss, 1995; Weisz & Weersing, 1999; Weisz, Weiss & Donenberg, 1992). For example, when testing interventions in routine practice settings, it may not be feasible to impose stringent selection criteria or withhold appropriate treatment from consumers in a control condition (Hoagwood, Hibbs, Brent & Johnson, 1995). Further, variables such as differential attrition and treatment drift are common in real world settings and the intensive therapist training and monitoring may not be available outside of the laboratory environment (Hoagwood, Hibbs, Brent, & Johnson, 1995). Engaging in effectiveness research requires an understanding of the characteristics of routine mental health settings and how they impact key aspects of intervention research.

Participant Selection. The careful selection of participants adhered to when conducting controlled efficacy trials is generally not possible in routine practice settings, nor does it generate a sample reflective of real world consumers. Estimates suggest that typical Randomized Controlled Trials of psychotherapy screen out about two-thirds of referred consumers (Westen & Morrison, 2001). For example, controlled trials testing the efficacy of psychotherapy often limit participants to those individuals with a primary, single diagnosis, excluding individuals experiencing co-occurring disorders or more challenging diagnoses such as personality disorders or substance abuse (Westen & Morrison, 2001). In routine treatment settings, co-occurring disorders are the norm rather than the exception (Norcross, Beutler & Levant, 2006); therefore, setting these stringent diagnostic inclusion criteria is typically not feasible in community settings. Further, excluding these individuals does not provide an accurate assessment of an intervention's utility in usual care settings. Moreover, it may not be feasible to establish control or comparison groups when conducting effectiveness research, as there are ethical dilemmas related to withholding appropriate treatment from presenting consumers assigned to control conditions (Merrill, Tolbert & Wade, 2003).

Treatment Adherence. Efficacy trials often utilize manualized treatment protocols that call for weekly therapy sessions over a set period of time, with successful completion generally requiring 13 to 18 sessions (Hansen, Lamber & Forman, 2002). In fact, a review of 28 Randomized Controlled Trials of psychotherapy representing 2109 consumers in 89 treatment conditions found that an average of 12.7 sessions were required for the majority of consumers to recover or experience meaningful improvement (Hansen, Lambert & Forman, 2002). This represents a stark departure from the realities

of routine practice settings and does not support community consumers' expectations of treatment. Hansen and colleagues' (2002) review went on to compare RCTs to routine practice settings. The researchers analyzed a national database representing 6,072 consumers treated within six routine practice settings, ranging from an employee assistance program to a state community mental health clinic. The results showed that consumers in the real world received an average of 4.3 therapy sessions. The median number of sessions across routine practice settings was 3. The reported treatment dosage is actually inflated, as 3,101 consumers who received only one therapy session were excluded from analysis (Hansen, Lambert & Forman, 2002). This is consistent with Garfield's (1994) work suggesting that between 25 and 50 percent of consumers across diverse treatment settings drop-out of psychotherapy by failing to return after an initial assessment or therapy session and Wierzbicki and Pekarik's (1993) findings that in general only 53% of consumers in routine treatment settings complete treatment.

Additionally, consumers in routine practice settings exhibit a preference for short-term, pragmatic interventions. Consumers seeking care in the real world often live with chronic mental health needs, yet do not seek care until faced with crisis situations, suggesting that these consumers do not seek treatment for long-term maintenance (Segal et al., 2002). Mental health services research further support consumer preferences, indicating that if improvement does not occur early, it likely will not occur at all (Miller, Duncan & Hubble, 2005). Further, consumers receiving community treatment are often restricted by financial considerations and access to insurance (Merrill, Tolbert & Wade, 2003). In total, what is known about routine treatment settings suggest that it is generally not feasible to implement manualized treatment protocols in the real world without

making adaptations related to dosage. In fact, researchers acknowledging the variability of dosage in community settings, suggest embracing this variability and not setting a predetermined number of “required” sessions (Merrill, Tolbert & Wade, 2003).

Therapist Training. Therapists providing treatment for efficacy trials are usually hired specifically for that role and given intensive training and supervision in the therapy under study. When conducting efficacy research, it is expected that therapists trained in an identified intervention will solely implement that one particular treatment. Further, it is assumed that the intervention is implemented consistently across therapists (Nathan & Gorman, 2002; Weisz, Ross & Hawley, 2005). Effectiveness studies tend to utilize therapists already practicing within the routine treatment settings. While the therapists may receive some structured training on the intervention under study, they must integrate their study cases with their existing caseloads, often moving back and forth between different types of treatment. This presents multiple challenges for effectiveness researchers. Not only do therapists in routine practice settings treat presenting consumers with more complex needs than those consumers carefully screened for efficacy research, while maintaining high caseloads and time consuming documentation required for billing, but these demands lead to burn out and clinician turnover (Proctor et al., 2007). . Overall, little attention has been paid to clinician characteristics or clinician perspectives that may influence the successful implementation of evidence-based care (Proctor et al., 2009; Proctor et al., 2007). However, clinicians’ ability to develop a therapeutic alliance with consumers, consistently associated with positive treatment outcomes across treatment modalities, may be compromised due to these real world demands (Bachelor & Howath, 1999). For example, effective clinical practice develops over time, as therapists

hone their skills and their confidence as they gain increased practice experience and supervision. This increased competence is likely to improve clinicians' ability to achieve a therapeutic alliance. However, the high turnover and burnout experienced by clinicians in routine practice settings may inhibit this process and negatively impact successful implementation of empirically supported interventions.

Strategies for Effectiveness Research. Effectiveness research is critical as it establishes evidence for what works in real world treatment settings and allows consumers in routine practice settings to benefit from state-of-the-art care. As the differences between laboratory or university settings and the routine treatment settings described above suggest, this is not an easy task. In order to inform practice in a meaningful way, effectiveness research must be responsive to the service system. Previous efforts in dissemination research have often carried the assumption that interventions can be transferred into routine service settings without modification and that a unidirectional flow of information is sufficient to achieve practice change (Mullen, Bledsoe & Bellamy, 2008). Theory development in implementation research indicates that the previous approach is not sufficient. Effectiveness research often requires treatment modifications and adaptations in order to make interventions applicable for particular client populations or practice settings (Proctor et al., 2009).

Scholars strongly advocate the use of more collaborative models such as the Evidence-Based Practice Process and Community Based Participatory Research models, in which researchers work collaboratively with multiple stakeholders, including practitioners, administrators, and consumers, who identify community needs and inform the research process (Heneggeler, 2002; Palinkas, Allred & Landsverk, 2005; Minkler &

Wallerstein, 2003). Virtually all implementation models acknowledge the interaction between researchers and practitioners as a core component that needs to be considered when translating empirically supported interventions to routine practice settings (Mullen, Bledsoe & Bellamy, 2008; Proctor et al., 2009), identifying the creation of agency-university partnerships as a key strategy (Johnson & Austin, 2006; Rogers, 1995). The face-to-face interchange between researchers and practitioners is deemed critical (Huberman, 1994; Innvaer et al., 2002), as it allows researchers to incorporate local knowledge from practitioners and identify empirically supported interventions that address practitioners' needs. For example, through the collaborative process, researchers have learned valuable information about practitioner preferences. Given the context of routine practice settings, it is not surprising that clinicians have exhibited a preference for implementing interventions perceived as being straight-forward and easy to understand and offering some advantage relevant to their particular practice setting (Berwick, 2003).

Although real world effectiveness studies cannot replace controlled trials, they can provide valuable information on transporting empirically supported treatments as well as effectiveness data for a given clinic (Merrill, Tolbert & Wade, 2003). When consumers do not receive efficacious care, they are unable to reach their full potential, as their ability to improve is compromised. It is the consumers demonstrating the most need, those seeking care in routine treatment settings, who are the least likely to receive empirically supported treatment (NIMH, 1999). Therefore the need to test empirical supported treatment within the real world setting is critical; however, few researchers examine treatment effectiveness in routine settings, as they are deterred by the challenges of community research. Social workers have both the clinical and research skills

necessary to fill this gap and subsequently inform clinical practice and ensure quality care for a vulnerable population of consumers.

2.2 STRUCTURAL FAMILY THERAPY

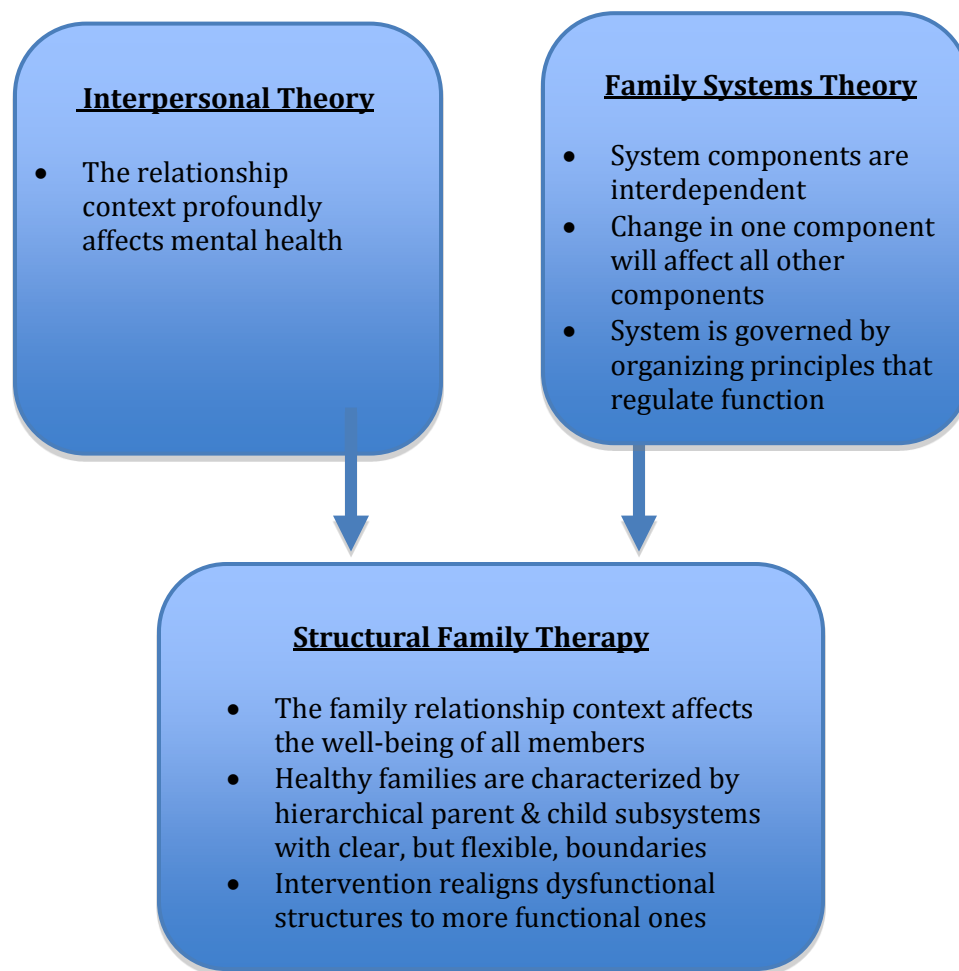
Family therapy has a strong evidence base for treating a variety of child behavioral health needs, yet little work has explored its utility in routine practice settings. Structural Family Therapy, developed by Salvador Minuchin and colleagues in the 1960s, is a pragmatic, short-term approach designed to address relationship problems within low-income, multi-problem families, therefore offering particular relevance for community treatment settings.

Minuchin's early clinical work in an inpatient facility for juvenile delinquents from poor families dealing with many issues greatly influenced his view of therapy (Minuchin, 1961). Upon observing that the improvements achieved through individual therapy often disappeared when the juveniles returned home, Minuchin and his colleagues began to view delinquency as a family problem and sought alternative treatment approaches to this end (Minuchin, 1978; Aponte, 1976). Minuchin's desire for new interventions coincided with the rise of modern family therapy, which greatly influenced his thinking (Haley, 1971). Minuchin focused on changing families rather than individuals, specifically identifying the reorganization of dysfunctional family structures and mobilization of family resources as important therapeutic strategies (Colapinto, 1982). This work laid the foundation for Structural Family Therapy.

Structural Family Therapy is guided by two primary principles: 1) the family is the primary social context of its members and 2) a systemic orientation (Minuchin, Colapinto, & Minuchin, 2007). Structural Family Therapy draws from two theoretical traditions: the interpersonal theory of psychiatry that stems from the work of Harry Stack Sullivan and family systems theory that is the root of the modern family therapy

movement (see Figure 1). The two theoretical traditions are introduced and described with special attention placed on aspects of the theories that guide SFT. Next, there is a detailed discussion of Structural Family Therapy, its connections to the aforementioned theories, and the evidence supporting interventions rooted in these approaches.

Figure 1. Theoretical Components of Structural Family Therapy



2.2.1 Theoretical Underpinnings

The Interpersonal Theory of Psychiatry. The interpersonal theory of psychiatry stems from the work of Harry Stack Sullivan (1953; 1956). Sullivan maintained that the most important determinants of mental health are the relationship context. This view stood in stark contrast to the largely individual and internally focused models predominant at the time, particularly Freud's psychoanalytic theory. It should be noted that Sullivan's work still acknowledged the importance of individual processes, though he asserted that they dynamically interacted with interpersonal and environmental influences in order to respond and assign meaning to the human experience (Evans, 1996).

Sullivan asserted that external factors, specifically interpersonal relationships, were essential to personality development as well as mental health (Sullivan, 1953). His work postulated that the psychosocial processes underlying normal and pathological interpersonal relationships were more similar than different. This idea, known as the one-genus hypothesis, became central to Sullivan's view of psychopathology and led him to explain that while interpersonal processes were the same for people regardless of mental health needs, people who had psychiatric disorders experienced a greater degree of pervasiveness, or difficulty, negotiating interpersonal relations (Sullivan, 1940; 1953). Therefore, Sullivan defined mental disorder as difficulties in interpersonal living or patterns of inadequate or inappropriate interpersonal relations (Sullivan, 1953). The theory assumes that these problematic patterns originate from psychosocial etiology, principally from difficulties in development resulting from constraints on the attainment of important needs (Sullivan, 1956).

Sullivan's theory, in fact, reframed the concept of psychopathology into problems of interpersonal living (Evans, 1996). This had significant consequences for the way people living with mental health problems were viewed and treated. Not only did Sullivan systematically challenge the barriers between normal and pathological, offering a more compassionate orientation toward people struggling with mental health problems, but he also redefined the therapeutic relationship by viewing the therapist as a participant-observer (Sullivan, 1953; Evans, 1996). Sullivan asserted that clients' interpersonal learning could not occur without feeling secure in their relationship with the therapist. The importance of establishing and maintaining an atmosphere of interpersonal security was a central tenet guiding Sullivan's work. He believed this was achieved through respectful, empathic listening, informed by the therapist's knowledge of human development and interpersonal processes as well as the client's expectation of benefit (Evans, 1996).

Sullivan's assertion that mental disorders resulted from difficulties in interpersonal living or inappropriate or inadequate personal relations, his belief that psychotherapy could effectively treat mental illness, and the importance he placed on the interpersonal nature of the therapeutic relationship, greatly influenced Structural Family Therapy.

Family Systems Theory. Family Systems Theory draws from General Systems Theory and cybernetics to create a framework for conceptualizing family organization and processes, therefore offering an explanation for abnormal behavior (Guttman, 1991; Hecker et al., 2003; Robbins, Mayorga & Szapoznick, 2004). General Systems Theory, based on biologists' observations that emergent properties of organisms and complex

non-biological phenomena are greater than the sum of their parts and that a change in one part of the system creates change in every other part of that system (Bertalanffy, 1968; Buckley, 1968). Cybernetics, the study of feedback processes within complex systems, asserts that systems use feedback to remain stable or to adapt to new circumstances (Wiener, 1948-1961).

Guided by these two theoretical orientations, scholars studying the family system developed a series of propositions and hypotheses explaining the interactive processes that organize interdependent family members. Primarily, Family Systems Theory asserts that a change in one family member's behavior inevitably leads to change in all family members. Further, the theory postulates that feedback within the family system either maintains homeostasis or leads to adaptation. The core concepts used to explain these relational processes include: boundaries, patterns of interaction, change, feedback, and complexity.

The system orientation views the family as a system that has boundaries and is organized into subsystems. The boundary around a family sets it apart from the wider social system, of which it is one subsystem (Carr, 2006). Family systems theory asserts that this boundary must be semi-permeable to ensure the family's adaptation and survival. While the boundary must be impermeable enough for the family to exist as a coherent system, it also must be permeable enough to permit the intake of information and energy from the larger social system, which is required for continued survival (Carr, 2006).

Maintaining these boundaries requires rules established through patterns of interaction. Family systems theory posits that patterns of interaction connect all family

members and determine the behavior of each family member as well as each family subsystem (Bateson, 1972, 1979). When there is a change in one family member's behavior, it impacts patterns of interaction within the entire system. The systems orientation argues that a family's patterns of interaction are governed by rules and are recursive. Theorists maintain that these rules can be inferred through repeated observation of family interaction, which leads to the identification of recursive patterns. These recursive patterns must be examined, as they can be associated with episodes of problematic behavior (Carr, 2006). Further, recursive patterns of interaction can be replicated within other parts of the system or even across generations.

Intrinsic to the emphasis placed on patterns of interaction, family systems theory posits that while an individual family member may present with problem behaviors, the behavior is actually caused and maintained by the mutual influence of interactions among family members. The mutuality of influence on problem behavior is referred to as circular causality. More recent contributions to Family Systems Theory assert that circular causality must be considered in conjunction with concepts of hierarchy and power and that mutuality of influence does not mean there is equality of influence (Haley, 1976; Leupnitz, 1988).

Family Systems Theory postulates that family systems include processes that prevent and promote change. These change processes can either perpetuate or ameliorate presenting problem behavior. In fact, a family's survival as a coherent system rests on its ability to maintain some degree of stability while having the capacity to evolve over the course of the lifecycle and deal with unpredictable or unusual stresses and demands (Carter & McGoldrick, 1999). Families typically develop recursive behavior patterns that

involve relatively stable rules, routines, and mechanisms that prevent disruption (Jackson, 1968); however, families must also have the resources to effectively adapt to changing demands or transition to one stage of the lifecycle to another. When families lack the resources for change, family systems theory argues that problem behaviors emerge. One member of the family system may develop problematic behavior that serves to maintain family stability and resist change (Haley, 1997).

Change within the family system is either deterred or encouraged through feedback. Family Systems theorists identify negative and positive feedback mechanisms that provide new information for responding to an event (Bateson, 1972). Negative feedback, also known as deviation reducing feedback, maintains homeostasis and prevents change within the family system, while positive feedback, or deviation amplifying feedback, encourages change. The new information resulting from feedback mechanisms may lead to two descriptions of the same event, which may help family systems change or adapt to problematic circumstances (Carr, 2006).

As family systems theory ultimately asserts that the actions of a single family member affect the entire family unit and that the family can use feedback to either remain stable or adapt to change, family models offer the possibility of addressing, directly and indirectly, the needs of all family members. The family systems orientation specifically maintains that problem behaviors caused by mutual influence, like the relationship that exists between maternal and child mental health, are appropriate targets for intervention. Family therapists observe and track these patterns and sequences of interaction in order to understand how problems develop and are maintained within families, and to identify and change unworkable or harmful transactional patterns directly between the family

members involved (Anderson & Stewart, 1982; Minuchin, 1974b; Minuchin et al., 1967; Szapocznik et al., 2002). Family therapies rooted in the family systems framework offer powerful here-and-now opportunities to change long-standing patterns of interaction that may be perpetuating mental health problems experienced by one or more family members (Sexton, Weeks, & Robbins, 2003).

2.2.2 The Structural Model of Family Therapy

Structural Family Therapy (SFT) draws from both Sullivan's Interpersonal Theory of Psychiatry and Family Systems Theory. SFT embraces the paradigm shift toward relational therapies, led by Sullivan's work, and asserts that the social and relational contexts, specifically the family, profoundly impact mental health (Minuchin, 1974). Further, SFT, like all modern family therapies, is rooted in Family Systems Theory and shares its central tenets and core concepts. Specially, SFT is based on the Family Systems Theory hypothesis that the symptoms or behavior problems experienced by one member of the family system can be understood as stemming from the family's underlying patterns of transactions, which are governed by rules and recursive in nature (Minuchin, 1974; Minuchin & Fishman, 1981; Vetere, 2001). However, the structural approach maintains that healthy families are characterized by a recognizable set of organizing structures and families that adopt dysfunctional patterns can be moved toward healthier structures through therapy (Minuchin, 1974; Minuchin & Fishman, 1981; Colapinto, 1982; Minuchin, Colapinto, & Minuchin, 2007).

In the Structural model, the organizational system of healthy families is hierarchical, with power relations regulated within and between subsystems (Minuchin, 1974). Structural Family Therapy identifies three primary subsystems within the family

system that provide specific tasks and make specific demands on members: the parental subsystem, the parent/child subsystem, and the sibling subsystem (Minuchin, 1974). The parental subsystem has the authority for the care and safety of children and fulfills major socialization requirements within the family (Minuchin, 1974; Minuchin & Fishman, 1981). If more than one person is responsible for caring for children, a clear parental coalition exists to meet the needs of adults for sexuality and companionship and that coalition interacts flexibly with children in order to meet their needs (Vetere, 2001). This coalition stresses teamwork and the ability to negotiate conflicting interests. Within the parent/child subsystem, parents provide nurturance, limit setting, the internalization of cultural values, and preparation for the child's gradual emancipation (Minuchin, 1974). This subsystem provides the context for affectional bonding, gender identification, and modeling. In addition, children learn to develop a degree of autonomy within unequal power relationships (Vetere, 2001). Finally, the sibling subsystem is the context within which children learn to cooperate, compete, resolve conflict, and prepare for peer relationships as they mature (Minuchin, 1974).

Structural family theorists view effective generational and interpersonal boundaries as crucial to the ability of the parental coalition to fulfill its roles and to help children accomplish their developmental tasks (Minuchin, 1974; Minuchin, Colapinto, & Minuchin, 2007). If a subsystem experiences interference from a family member outside of that subsystem, it will not be able to achieve its set goals and demands within the larger family system (Colapinto, 1982). For example, if a child crosses generational boundaries and forms a coalition with a parent, the parental subsystem's power and authority is undermined and parents may experience conflict within their relationship.

While families must maintain a hierarchical organizational structure to effectively function as a cohesive system, the structural model posits that family systems must also have the ability to adapt and change as family members mature and experience life cycle transitions (Minuchin, 1974; Minuchin & Fishman, 1981; Colapinto, 1982). Structural Family Therapy asserts that healthy families adapt to stress in a way that maintains continuity while making restructuring possible. Therefore, the strength of the family system depends on the ability of family members to mobilize alternative transactional patterns when internal or external stresses demand restructuring (Colapinto, 1982; Minuchin, Colapinto, & Minuchin, 2007). If families respond to stress by reapplying the same transactional patterns they've always used, family members may experience a maladaptive reaction to the changing environment. These dysfunctional patterns often result in symptomatic behavior. These behaviors result in shifts in organizational patterns such as problematic cross-generational alliances, enmeshed or disengaged individual relationships, and distorted communications. Subsystems and hierarchies of authority may become dysfunctional, especially when they must deal with growth, change, stress, or the inevitable conflicts that occur in families over time. These problematic organizational patterns maintain dysfunction in individual members and are unlikely to change without intervention (Minuchin, 1974; Minuchin & Fishman, 1981; Colapinto, 1982; Minuchin, Colapinto, & Minuchin, 2007).

As structural theorists view dysfunction as related to family stagnation, the model asserts that a therapeutic solution requires modification of the family structure, often resulting in changing the relative positions of family members (Minuchin, 1974; Minuchin & Fishman, 1981; Minuchin, Colapinto & Minuchin, 2007). The Structural

Family model maintains that change requires joining, in which the therapist creates a new subsystem with the family group (Colapinto 1982; Vetere, 2001). Once this new subsystem is created, the therapist encourages the families to enact their problems in session in order to explore the family structure, identify areas of strength and resilience, and assess the family's flexibility and potential for change (Minuchin, 1974; Minuchin & Fishman, 1981). The therapist then fulfills a paradoxical role in which the limits of the family system are pushed, thus altering their patterns of transactions and increasing their capacity to tolerate stress, while making sure not to exceed their ability to innovate and adapt (Minuchin, Colapinto, & Minuchin, 2007; Colapinto, 1982; Vetere, 2001). This process releases family members from stereotyped positions or functions, enabling the family system to mobilize underutilized resources and improve its ability to cope with stress and conflict (Colapinto, 1982). Once the dysfunctional patterns of transaction are outgrown, individual problem behaviors identified as the presenting problem, lose their support in the system and become unnecessary from the view of homeostasis (Minuchin, 1974; Minuchin, Colapinto, & Minuchin, 2007).

2.2.3 Empirical Support for Structural Family Therapy

As SFT is guided by both the Interpersonal Theory of Psychiatry and Family Systems Theory, this section examines empirical support for these theoretical orientations as well as evidence supporting SFT in and of itself.

Evidence Supporting The Interpersonal Theory of Psychiatry. The most well-known treatment approach recognizing the importance of interpersonal issues in treating mental illness is Interpersonal Psychotherapy (IPT), which draws directly from the Interpersonal Theory of Psychiatry (Sullivan, 1953; 1956) as well as attachment bonds and social roles

(Bowlby, 1988). IPT was originally developed by Klerman and Weissman (Klerman et al., 1984; Klerman et al., 1987) to treat depression. This short-term manualized therapy focuses on identifying and ameliorating one of a set of relationship issues specified in treatment conceptualization. Over the past thirty years, numerous studies have documented the effectiveness of versions of this intervention for the treatment of depression (Frank et al., 2005; Weissman, 2000; Wolf & Hopko, 2007). Extensions of IPT to a variety of other disorders are now being proposed or tested. Disorders under study include borderline personality disorder, panic disorder, post-traumatic stress disorder, substance abuse, and binge eating disorder (Bellino et al., 2006; Lipsitz et al., 2006; Robertson et al., 2004; Rounsaville et al., 1983; Tanofski-Kraff et al., 2007). The special relevance of the relationship context for women is noted by the fact that IPT trials often specifically address women's depression (e.g. Frank et al., 2007). Another recent individual model of intervention based on addressing the interpersonal has also demonstrated promising preliminary results (Addis & Jacobson, 1996). Jacobson and colleagues designed this intervention to facilitate the development of new interpersonal behaviors and contextual transactions, noting that depression occurs when people's actions are not met with positive reinforcement. Controlled intervention trials revealed no difference in outcomes when comparing this approach to cognitive behavioral therapy at either termination or 2 year follow-up, suggesting that treating depression by helping to activate people interpersonally is as effective as helping them change their thinking (Gortner, Gollan, Dobson, & Jacobson, 1998; Jacobson, Dobson et al., 1996). These studies provide additional evidence for the value of interventions that address

interpersonal functioning (Jacobson & Christensen, 1996; Jacobson et al., 1984; Christensen & Jacobson, 2000).

Evidence Supporting Family Systems Theory. Children have consistently been shown to benefit from family therapy, sometimes with very large effect sizes. Systematic reviews demonstrate that systemic family treatment models, all rooted in family systems theory, positively impact a number of child and adolescent outcomes (Brent et al., 1997; Diamond & Siqueland, 2001; Hoagwood, 2005; Pinsof, Wynne, & Hambright, 1996; Shadish et al, 1995), ranging from child and adolescent conduct disorders and communication and problem solving to more serious problems such as aggression, delinquency, and schizophrenia (Carr, 2000; Halligan et al., 2007; Goodman & Gotlib, 1999; Hammen & Brennan, 2002).

Shadish and colleagues' (1993) meta-analysis reviewed 71 randomized controlled studies published through 1988 assessing the effects of family therapy. The fact that there were so many randomized trials conducted by 1988 is an important finding in and of itself, as few other forms of psychotherapy have been studied this often with such rigorous methodology (Shadish et al., 1995). However, the term family therapy encompasses a wide range of interventions and it is not always clear what model has been delivered (Cottrell & Boston, 2002). The 71 studies reviewed were grouped according to their orientation of family therapy, including systemic, behavioral, humanistic, eclectic, and undetermined, with 12 studies specifically examining systemic family therapy. Participants receiving systemic family therapy did statistically significantly better than participants in untreated control groups with an effect size of 0.25 (Shadish et al., 1993; Shadish et al., 1995). Systemic family therapy was most often utilized to treat child and

adolescent conduct disorders ($n=8$) and had a statistically significant effect ($d = .26$).

Further, pairwise comparisons suggested no significant differences between systemic family therapy and behavioral family therapy (Shadish et al., 1993).

Outcome studies examining family therapy have almost exclusively addressed child outcomes though some positive effects on parents have been described (Herschell, Calzada et al., 2002). For example, Schuhmann and colleagues (1998) found mother's parenting distress was reduced after participation in a family treatment and Liddle's (2002) investigation of family therapy reported increases in parental functioning, but neither work explicitly examined mothers' mental health symptomatology. Further, the effects of family interventions in real world practice settings have not been studied much (Shadish & Baldwin, 2003).

Evidence Supporting Structural Family Therapy. Although the original Structural model has rarely been systematically studied, it continues to be widely used by clinicians (Cottrell & Boston, 2002). Two identified studies tested Structural Family Therapy (SFT) and provide empirical support for its utility treating children and adolescent conduct and attention problems (Szapocznik et al., 1989; Barkley et al., 1992).

Szapocznik and colleagues (1989) compared SFT, as described by Minuchin and his colleagues, with psychodynamic child therapy and a no treatment control to treat sixty-nine 6-12 year old Hispanic boys presenting with behavioral and emotional problems. Structural Family Therapy and psychodynamic child therapy were equivalent in reducing the children's behavioral and emotional problems and improving the psychodynamic ratings of child functioning and both were more effective than the no treatment control group. SFT was more effective than psychodynamic child therapy at

maintaining family functioning one year post-treatment (Szapocznik et al., 1989). In fact, family functioning among the psychodynamic child family therapy group deteriorated at follow-up. Only nuclear families were included in this study and both parents had to be Hispanic. Additionally, families were recruited through advertisements. These factors limit the generalizability of findings to routine practice settings.

Barkley and colleagues' (1992) study compared SFT, as specified by Minuchin and colleagues, to behavior management training and problem-solving and communication training for sixty-one 12-18 year olds presenting with Attention-Deficit Hyperactivity Disorder. Findings suggest all treatments resulted in significant reductions in negative communication, conflicts, and anger during conflicts and improved ratings of school adjustment and reduced internalizing and externalizing symptoms. Further, this is the only identified study to examine mothers' mental health symptomatology, finding that depressive symptoms significantly decreased with SFT (Barkley et al., 1992). However, 90% of families receiving SFT were comprised of married couples, with fathers participating in treatment (Barkley et al., 1992). This likely led to stronger parental coalitions that helped regain organizational family structures and manage children. Again, this study was comprised of families referred to an ADHD clinic that met stringent eligibility criteria, likely not representative of the families seen in real world practice settings. No studies of SFT have been conducted in settings serving the very population it was designed for: low-income, multi-problem families.

Over the past twenty years, variations of the Structural Family Therapy model have been tested, demonstrating substantial benefits for families with very difficult to treat problems and disorders. This is a testament to the power and perceived effectiveness

of SFT. Many interventions stemming from the Structural model now have an established evidence base, including Brief Strategic Family Therapy (BSTF) for adolescent behavior problems (Santisteban & Szapocznik, 1994; Robbins et al., 2003); Multisystemic Family Therapy for delinquency and substance abuse (Henggler et al., 1986; Schoenwald et al., 2003); and Multidimensional Family Therapy for drug and alcohol abuse (Liddle et al., 2002). BSTF uses the same basic principles of the SFT model, whereas therapists engage in the processes of joining, diagnosing patterns of transaction, and restructuring, but was specifically developed for Hispanic families. Both Multisystem Family Therapy and Multidimensional Family Therapy share SFT's focus on restructuring dysfunctional patterns of transaction and restoring an organizational hierarchy, but also acknowledge the role of other societal systems, such as peers, school, child welfare, mental health, and juvenile justice, on the presenting child's behavior. This body of work clearly demonstrates the power and usefulness of family approaches based on Structural Family Therapy for a range of severe problems. The findings also suggest that it is very likely to be valuable when used for its original purpose, as a short, focused therapy for interpersonal and behavioral problems experienced by low-income, multi-problem families.

2.3 THE INTERCONNECTION OF MOTHERS' AND CHILDREN'S MENTAL HEALTH NEEDS

Maternal mental health symptomatology and children's behavioral health needs are common, debilitating, and tend to coexist (Diaz-Caneja & Johnson, 2004; Lyons-Ruth et al., 2003). When mothers experience mental health symptomatology, their children fare worse. When mothers care for a child with behavioral health needs, their own mental health suffers. If mothers and children do not receive appropriate, effective mental health treatment, it is likely that both family members will continue to experience challenges. As Structural Family Therapy (SFT) offers an empirically supported intervention that systemically addresses interpersonal relationship problems that lead to dysfunctional patterns of interaction, it is logical to suggest that SFT is relevant and appropriate to concurrently address mothers' and children's mental health needs.

This section reviews the prevalence of mothers' and children's mental health needs, the reciprocal impact of these needs, and the low levels of treatment utilization among mothers with mental health needs. In conclusion, the section provides a rationale for using SFT to treat both mothers' and children's mental health needs.

2.3.1 Prevalence of Mental Health Needs Among Mothers and Children

Mothers and children both experience high rates of mental health needs. Mood disorders are prevalent among women and peak during childbearing years (Kessler et al., 1993; Kessler et al., 2005; Regier & Burke, 1987; Robins et al., 1984; Weissman et al., 1988, 1996). Estimates from nationally representative data found that approximately 25% of mothers meet diagnostic criteria for lifetime prevalence of an affective disorder, such as depression, and almost one-third of mothers meet criteria for lifetime prevalence of an

anxiety disorders (Nicholson et al., 2002). Further, research shows that as many as one in five children meet criteria for an Axis I psychiatric disorder (Shaffer et al., 1996).

Rural mothers and low-income mothers are at increased risk for experiencing mental health needs. This has important implications for the current study, conducted within a semi-rural community mental health setting. Huang and colleagues' (2007) used longitudinal data to assess within group differences among 7676 mothers with depression, finding that rural mothers experienced significantly higher levels of depressive symptomatology than their urban and suburban counterparts. Forty-four percent of rural mothers reported depressive symptoms, compared to the overall prevalence rate of 24.7%, and rural mothers were more likely to experience moderate to severe depressive symptomatology than their urban and suburban counterparts. Further, studies consistently suggest that poor women, especially those with young children, are more likely to experience mental health needs when compared with other women (Hall et al., 1985; Kaplan et al., 1987; Pearlin & Johnson, 1977; Wang et al., 2005). The increased risk experienced by these women suggests that mental health researchers need to focus more attention on these vulnerable populations.

Literature also suggests that childcare responsibilities impact the prevalence rates of mood disorders among mothers, specifically maternal depression (Brown & Harris, 1978; Brown & Purdo, 1981) and the relationship is exacerbated when mothers care for children with behavioral health needs (Breslau & Davis, 1986; McLennan et al., 2001). This finding is exemplified by a growing number of studies examining mothers whose children present for behavioral health treatment. Studies utilizing bottom-up sampling strategies, in which researchers identify ill children and then assess their mothers,

consistently demonstrate that mothers caring for children with behavioral challenges experience strikingly high levels of need themselves. Empirical findings suggest that as many as 60% of mothers whose children present for mental health treatment meet criteria for depression or anxiety disorders (Kaufman et al., 1998; Rishel et al., 2006a, 2006b; Swartz et al., 2005).

In a controlled treatment trial for suicidal adolescents, Kaufman and colleagues (1998) found that 71% of mothers met criteria for an Axis I disorder, which includes major depression. It is arguable that the crisis situation, having a suicidal child, experienced by Kaufman's sample impacted the validity of his findings. However, a series of studies conducted within the community mental health setting confirm these findings. Rishel and colleagues' (2006a) examination of 272 mothers bringing their children for treatment at three community mental health centers within the greater Pittsburgh area found that 57% of mothers met criteria for one or more mental health disorders according to Patient Health Questionnaire scores. Depression and anxiety were the two most common disorders, with 42% and 40% of mothers meeting the respective diagnostic criteria. Two additional community studies were conducted in non-urban areas, with findings further supporting the high mental health needs among rural mothers. Swartz and colleagues' (2005) study examining the psychiatric diagnosis of mothers bringing their school age children to a rural community pediatric mental health clinic found that 61% of mothers met criteria for an Axis I disorder. Of those mothers meeting diagnostic criteria, 77% had either depression or anxiety disorders (Swartz et al., 2005). Further, a study of 180 mothers bringing children for community treatment, found 64% of mothers met diagnostic criteria for one or more psychiatric diagnosis according to the

SCID, with Major Depressive Disorder by far the most common diagnosis (Rishel et al., 2006b).

It should be noted that a group of Columbia University researchers found lower, yet still substantial, rates of mental health need among 117 mothers bringing their children for outpatient evaluation or treatment at a university research clinic, as 31% screened positive for current psychiatric disorder, with 14% of mothers meeting criteria for depression and 17% of mothers meeting criteria for anxiety (Ferro et al., 2000). It may be that the characteristics of this sample of mothers, urban, Latina and Spanish speaking, were qualitatively different from the other community samples.

2.3.2 Reciprocal Relationship Between Maternal and Child Mental Health Needs

When mothers and children have co-existing mental health needs, both family members' fare worse. This reciprocal relationship hits families hard.

A large body of work shows mothers' mental health symptomatology, specifically depressive symptomatology, negatively impacts children across a wide range of outcomes (Beardslee et al., 2003; Coiro, 2001; Cummings & Davies, 1994; Downey & Coyne, 1990; Goodman & Gotlib, 1999; Hammen & Brennan, 2003; Weissman, Warner, et al., 1997; Weissman, Feder, et al., 2004). When their mothers have mental health needs, children are at risk for adjustment, developmental, and psychosocial problems and are at increased risk of developing behavioral health needs themselves (Beeber & Miles, 2003; Dipietro et al., 2006; Downey & Coyne, 1990; Lyons-Ruth et al., 2000; Weissman et al., 2006). Children of depressed mothers display greater social, behavioral, and academic impairment than children of non-depressed mothers from infancy through adolescence (Goodman & Gotlib, 1999; Luoma et al., 2001). In fact, infants and children

of depressed mothers are more fussy, receive lower scores on measurement of intellect and motor development, have more difficult temperaments, less secure attachments to mothers, more negative reactions to stress, lower self-esteem, and higher levels of behavior problems (Lyons-Ruth et al., 2000; Boyd et al., 2004; Moehler et al., 2006; Yonkers et al., 2001). These negative developmental correlates put these children at an increased risk of developing mental health symptomatology. One longitudinal study found maternal depression and anxiety in early childhood was a significant predictor of higher rates of children's depression and anxiety symptoms at age 14 (Spence et al., 2002). Further, point prevalence rates of psychiatric disorder among children of depressed parents are estimated to be 2 to 5 times above normal, ranging from 41-77% (Beardslee et al., 1992; Beardslee et al., 1998; Weissman et al., 2006). For children in mental health treatment, mothers' mental illness negatively affects their treatment outcomes as well. Children whose mothers have mental health needs benefit less from treatment (Rishel et al., 2006), are more likely to drop out of treatment (Dover et al., 1994), and are more likely to experience recurrence of illness (Kaufman et al., 1998) than children whose mothers are healthy.

A smaller, but consistent, literature reveals that the presence of children with behavioral health needs in the home negatively impacts mothers' mental health. Living with children who experience an emotional or behavioral disturbance influences maternal functioning and possibly increases the risk of and exacerbates maternal depression (Elgar et al., 2004). Mothers of disruptive children report more life stress and maternal aggravation than mothers whose children are not disruptive (Barkley, et al., 1992; Harrison & Sofronoff, 2002; Pfefferle et al., 2009). Pelham and colleagues (1997)

showed that under controlled conditions, increasingly deviant child behaviors caused increased depression, anxious, and hostile feelings, as well as alcohol consumption in parents. Civic and Holt (2000) found that mothers who reported three or more adjustment problems in their children were 3.6 times more likely than other mothers to show elevated scores on self-report screens for depression. The presence of an ill child in the home is also associated with increased childcare burdens likely to increase mothers' psychiatric distress. Breslau and Davis's (1986) work reported a rise in maternal depression with the presence of an ill child in the home and, more recently, McLennan and colleagues' (2001) analysis of a nationally representative sample of 7537 mothers revealed that poor child health status was related to mothers' elevated depressive symptoms.

The relationship between maternal and child mental health is multi-faceted and complex. Models examining the impact of maternal mental health on child mental health identify a variety of contributing risk factors, including shared genetic vulnerabilities, psychosocial variables, such as attachment, child discipline, and family functioning, and social capital, including income and social resources, while finding that the father/child relationship and child temperament act as moderators (Goodman & Gotlib, 1999).

While not all aspects influencing this complex reciprocal relationship are modifiable, it is likely that modifying psychosocial influences, such as family functioning, may benefit both mothers and their children. Treating mothers would benefit their own mental health as well as the mental health of their children. However, mothers are unlikely to seek treatment or accept referrals for their own care.

2.3.3 Mothers' Treatment Utilization

Mothers with mental health needs whose children present for behavioral health treatment are unlikely to receive care themselves or accept referrals for individual treatment (Ferro et al., 2000; Kaufman et al., 1998; Rishel et al., 2008; Swartz et al., 2005). While few studies examine mothers' service use or referral acceptance, those that do indicate that less than half of mothers whose children presented for treatment were receiving care or accepted a referral for treatment (Ferro et al., 2000; Kaufman et al., 1998; Rishel et al., 2008). This pattern was similarly demonstrated among rural mothers. Swartz and colleagues (2005) reported that just one-third of mothers meeting criteria for a psychiatric disorder when initiating services for their child within a rural community treatment setting received mental health treatment themselves.

It is imperative for mothers to seek care for their own sake and for the sake of their children. There is no question that mothers, especially low-income mothers commonly seen within community treatment settings, experience a multitude of realistic barriers to care, including the relative lack of services and resources in lower income communities as well as challenges related to finances, transportation, and child care (Armstrong, Ishiki, Heiman, Mundt, & Womack, 1984; Diamond & Factor, 1994; Greeno, Anderson, Sheer, Mike, 1999; Kendall & Sugarman, 1997; Maynard, Ehreth, Cox, Peterson, & McGann, 1997). Therefore, low rates of treatment participation among mothers may reflect that, in the context of so many daily difficulties, seeking treatment seems like one more burden (Kazdin, 2000; Owen, et al., 2002; Verhulst, & van der Ende, 1997); yet, these mothers overcome numerous practical barriers to initiate services for their children. Qualitative work exploring mothers' perceptions of treatment suggest

that they find individual therapy unacceptable (Anderson et al., 2006; Nicholson et al., 1998). Mothers reported feeling as if individual treatment was not necessary, perceiving their problems as a direct result of their child's problems and, under the circumstances, seeing their symptomatology as a normal response to their life events. Further, mothers perceived individual therapy as a risk, fearing the stigmatization of a mental health diagnosis would cause them to lose custody of their children due to being perceived as an unfit mother (Anderson et al., 2006; Brockington, 1996; Nicholson, Sweeney, & Geller, 1998). This suggests that the mental health service system is not sensitive to mothers' needs and may reflect a lack of cultural competency. Despite reluctance to seek care for themselves, mothers reported an increased desire for involvement in their child's treatment (Anderson et al., 2006).

When mothers who have children in mental health treatment do not seek treatment or accept referrals for care for their own needs, they unknowingly contribute to a negatively reinforcing cycle. Mothers living with mental health needs whose children develop behavioral health needs find it difficult to juggle the mental health treatment needs of multiple affected family members, often putting their own care behind their children's. Therefore mothers' mental health needs remain unaddressed and impairments remain in maternal interpersonal functioning and parenting skills, further contributing to poor maternal and child outcomes (Swartz, et al., 2008). Further, if mothers do not engage in services for themselves, they cannot benefit from empirically supported treatment and subsequently, unconsciously perpetuate their children's problems.

Since mothers are not seeking care, it is likely that the treatment they are offered is not acceptable to them. It is essential to identify and offer interventions that align with

mothers' views of treatment. Given the emphasis that mothers place on the interrelated status of their own and their child's behavior, family therapy has great potential to provide an empirically supported, acceptable way to simultaneously address maternal needs and child problems. Family therapy has a strong evidence base for treating a variety of child behavioral health needs (Shadish et al., 1993; Shadish et al., 2003), yet also emphasizes child management strategies and attends to mothers' needs (Minuchin & Fishman, 1982). Currently, studies testing family therapy have almost exclusively focused on child outcomes. However, the theories underlying family approaches suggest they should be effective for mothers for the same reasons they work for children.

2.4 SUMMARY

Consumers seeking routine outpatient mental health treatment are unlikely to receive empirically supported treatment, with rural consumers among those least likely to obtain evidence-based care (Wang et al. 2005). Family therapy has a strong evidence base when tested in controlled laboratory or university settings (Shadish et al., 1993; Shadish et al., 2003), though little work has examined its effectiveness in routine practice settings. Structural Family Therapy, specifically designed to address behavioral and interpersonal problems of low-income, multi-problem families, offers an appropriate, empirically supported intervention for consumers seeking care within community treatment settings (Barkley et al., 1992; Minuchin, 1974; Szapocznik et al., 1989). The SFT model's short-term, pragmatic approach aligns with treatment preferences of real world consumers and its basic, yet robust features are easily trained and congruent with providers expressed preferences for simple interventions.

Further, SFT appears to be a particularly relevant model for addressing the known link between maternal and child mental health needs that has been demonstrated among community mental health consumers. Mothers whose children have behavioral health needs have well-documented mental health needs as well as low rates of acceptance for individual treatment (Ferro et al., 2000; Kaufman et al., 1998; Rishel et al., 2006a; Rishel et al., 2008; Swartz et al., 2005), with rural mothers and low-income mothers particularly vulnerable to this disparity (Huang et al., 2007; Wang et al., 2005). Further, as mothers demonstrate a commitment to their children's treatment, perceive their own distress as linked to, if not caused by, their children's distress, and believe individual treatment contains unacceptable risks, it is likely that family therapy offers an acceptable way to

treat mothers' mental health needs (Anderson et al., 2006; Nicholson et al., 1998).

Existing research has almost exclusively examined the impact of family therapy on child outcomes, though the intervention's systemic orientation suggests it should be effective for mothers as well. There is also a dearth of qualitative research exploring mothers' perceptions of their mental health needs and treatment, which is important for identifying interventions acceptable for this population. The current study addresses these gaps in the literature by examining the effectiveness, acceptability, and sustainability of family therapy for mothers' mental health symptomatology, maternal functioning, and children's mental health symptomatology. This work gains added relevance as it tests family therapy in a semi-rural setting, typically understudied though serving vulnerable consumers.

3.0 METHODOLOGY

3.1 OVERALL DESIGN

The current project used pilot data collected as part of an on-going research collaboration between a semi-rural community mental health clinic in southwestern Pennsylvania and a mental health services research team at the University of Pittsburgh with methods approved by the University of Pittsburgh Institutional Review Board. The major aim of the original project was implementing an empirically supported intervention, Structural Family Therapy, for children initiating treatment within the community mental health setting and their families. The original project grew out of an agency-recognized need for family therapy within an outpatient community mental health setting. Members of the mental health services research team worked with clinicians and administrators in identifying Structural Family Therapy as an empirically supported intervention appropriate for routine practice settings. The Structural Family Therapy model utilizes very basic principles of family therapy and is considered to be among the most easily trained and implemented family model. The collaborative team worked together to design adaptations necessary to increase the model's utility for this particular outpatient community mental health clinic, with the idea that it would be useful for other routine outpatient settings as well.

This mixed methods dissertation study examined the effectiveness, acceptability, and sustainability of Structural Family Therapy for mothers and their presenting children who initiated mental health treatment within the semi-rural community mental health setting. The quantitative portion of this work consists of a one-group pre-/post-test design, with one baseline and two follow up time points, to assess Structural Family Therapy's effectiveness for mothers' mental health symptomatology, mothers' functioning, and children's mental health symptomatology. Thirty-one families received Structural Family Therapy. The mother and the presenting child from each family completed standardized outcome measures at baseline and two follow up time points, conducted three months and six months after the baseline assessment. The qualitative portion of this work consists of semi-structured, non-leading, engagement focused interviews with a randomly selected subsample of sixteen of the thirty-one mothers who received SFT. These interviews were analyzed for themes regarding mothers' perceptions of their own needs and the family treatment, and, together with descriptive analysis of treatment satisfaction measures, address the acceptability and sustainability of this intervention.

3.2 INTERVENTION IMPLEMENTATION

As part of a collaborative research infrastructure, a mental health services research team at the University of Pittsburgh worked closely with agency administrators, clinicians, and staff to adapt Structural Family Therapy in situ. This collaborative process was necessary to implement the intervention within the real world community mental health setting. Agency clinicians identified a need for family approaches to child therapy. When “fixed” children regressed after completing individual therapy, frustrated clinicians attributed this to the child’s “broken” home environment. The clinicians’ observations were consistent with the research team’s previous findings related to the reciprocal nature of maternal and child mental health and mothers’ unmet treatment needs (Rishel et al., 2006a, 2006b; Rishel et al., 2008; Anderson et al., 2006).

The collaborative team identified and selected Structural Family Therapy (SFT) for implementation because it was specifically developed for low-income, multi-problem families, similar to the population commonly served by outpatient community mental health settings (Minuchin, 1974). Further, SFT utilizes a straightforward yet powerful model, designed to be among the easiest trained and accessible to para-professionals (Minuchin, 1974). In addition, SFT aligns with consumers’ desire for practical, short-term treatment. The research team engaged in an implementation effort, in which SFT was adapted in situ to increase its applicability to this particular community mental health settings, with the intent that the adapted model would apply to routine, outpatient settings generally.

The implementation effort was led by a nationally recognized expert in the field of family therapy, Dr. Carol Anderson, and a local clinical authority and educator, Kathy

Werries. Dr. Anderson, a senior member of the University’s mental health research team, was trained at Minuchin’s clinic by his colleague, Braulio Montalvo. Her work led to the development of psychoeducation and emphasized women’s experiences with family therapy. Ms. Werries, the agency’s Director of Family-Based Therapy, has more than 20 years of experience providing family therapy in the community mental health setting, training and supervising clinicians to administer family therapy, and teaching masters level clinical courses focused on systems approaches and family therapy. Together with clinicians and clinical administrators in the agency’s outpatient division, Dr. Anderson and Ms. Werries adapted the implementation of the Structural Family Therapy model for delivery in a community mental health outpatient setting. The adaptations developed in situ were meant to emphasize the basic, robust features of SFT and make it deployable in the context of low-intensity outpatient therapy. The central tenets of the standardized model were implemented without adaptation. Adaptations for implementation included: 1) structuring the treatment around four-session renewable contracts; 2) adopting a strengths-based, collaborative orientation to treatment; 3) strengthening the focus on engagement, especially of the mother; and 4) emphasizing elements of treatment that directly address the child’s problems as well as the mother’s problems (see Table 1).

Table 1. Summary of Structural Family Therapy Adapted for Outpatient

Community Mental Health Setting

	Model Feature	Description
<i>Core Elements Retained from Standardized SFT Model</i>		
	1) Hierarchical Organizational Structure	Treatment reinforced need for hierarchical organization structure in order to regulate power dynamics and ensure healthy family functioning.

	2) Role of Family Subsystems	Treatment identified and supported the need for three distinct subsystems to fulfill needs of parents and children while maintaining boundaries of the hierarchical organizational structure.
	3) Generational and Interpersonal Boundaries	Treatment focused on restoring boundaries that support hierarchical organization of the family and encourages healthy family functioning
	4) Adaptability	Treatment encouraged flexibility of family system in order to effectively revise patterns of interaction to reflect changes in the life course.
	5) Joining	Therapist created and entered new family subsystem in order to assess family members' patterns of interactions and address dysfunctional patterns.
	6) Enactments	After joining, therapist encouraged family's ability to adapt by pushing them to overcome dysfunctional patterns of interaction presented in session.
<i>Model Adaptations for Implementation in Outpatient Community Mental Health Setting</i>		
	1) 4 Session Renewable Contracts	Treatment structured around 4 session contracts agreed upon by all family members. Consistent with community mental health consumers desire for short-term, pragmatic care.
	2) Strengths-based, Collaborative Treatment Orientation	Treatment overtly solicited mothers' perceptions of her own and her child's problems in order to collaboratively set goals and explore inconsistencies. This modernized SFT's approach to gender roles and made it more applicable for single mothers.
	3) Maternal Engagement	Treatment focused on relationship context, encouraged mothers' feedback in early joining sessions, and emphasized that help seeking acknowledged mothers' admirable

4) Maternal/Child Mental Health Link	<p>commitment to child's well-being. This addressed mothers' desire for increased involvement in child's treatment.</p> <p>Treatment placed a more intense focus on interpersonal issues related to both children and mothers' mental health needs and addressed structural features related to maternal mental health needs. This addressed mothers' perceptions that their own mental health needs often stem from their child's behavioral health needs.</p>
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Treatment was structured around explicit, time-limited, renewable contracts that included all family members. Despite the seriousness of many presenting problems encountered in the community mental health setting, the initial treatment contract was limited to four sessions. Contracts defined the who, when, where, and how of treatment, stressing the collaborative nature of the therapeutic relationship. Contracts also emphasized this strengths-based, collaborative approach allowing for the establishment of specific, attainable, and mutual goals as well as the frequent review of goals and progress. This adaptation was designed to promote both engagement and sustainability as consumers within the community mental health setting exhibit preference toward short-term, pragmatic interventions. Dr. Anderson and Ms. Werries' clinical experience led them to expect that the duration of treatment would most likely consist of one contract. Considering consumer preference and that fact that, on average, consumers in routine practice settings attend 4.3 treatment sessions (Hansen et al., 2002), it is reasonable to anticipate that participants' treatment would consist of one four-session contract.

Earlier versions of family therapies, including Structural Family Therapy, were highly authoritarian and often held mothers responsible for their children's problems as

well as overall family functioning. As this strategy is incongruent with current standards of care, this adaptation emphasized including an initial assessment that overtly solicited mothers' perceptions of their own and their children's problems. This allowed for the exploration of inconsistencies between maternal and clinician perceptions and focused on collaborative goal setting. In ongoing treatment, this adapted model asks clinicians to solicit regular maternal feedback about the impact of sessions, and adapt their interventions accordingly. Not only does this adaptation modernize the treatment model, it brings it in line with current agency and therapy practices.

This adaptation included explicit preparation for treatment in order to strengthen family engagement and communicate the treatment's focus on the relationship context. At the start of treatment, consumers were given information about what the treatment was, why the agency thought it worked, how it related to the presenting child problem, and the practical details of time, frequency of sessions, topics, and the therapist's role. Further, early joining interventions encouraged the mother and subsequently reinforced her commitment to the intervention by emphasizing her admirable commitment to her child's well-being, her treatment participation as evidence of her good mothering, and her attention to her own needs as being in the best interest of her child. This aspect of the therapeutic relationship was continually emphasized by soliciting maternal feedback in regards to the therapist's efforts to restructure the family and enhanced support for maternal functioning (i.e. reassign maternal tasks to diminish caretaking burden).

Finally, this adapted model of Structural Family Therapy included a more intense focus on the interpersonal issues specifically related to maternal mental health needs and explicitly addressed structural features related to maternal mental health. For example,

the intervention facilitated a family structure with strong generational boundaries to decrease the acting out of a child and thus creating a less stressful environment for both the mother and child. In addition, this adaptation provided mothers with pragmatic help in managing their child's behavior.

Dr. Anderson and Ms. Werries provided training in the standardized model of Structural Family Therapy and implementation adaptations to a group of agency outpatient clinicians. Clinicians were self-selected to participate in the training. All study clinicians were master's level, licensed mental health professionals. Allowing clinicians to self-select allowed for study clinicians who were motivated to learn and presumably interested in implementing a new intervention.

The training introduced the major elements of Structural Family Therapy, focusing on the model's straightforward system of understanding relationship problems. The training included ten weekly sessions, where clinicians met with Dr. Anderson and Ms. Werries once a week for 90 minutes. The training was held at the agency and incorporated didactic information, case studies, video, role-play interviews, discussions, and selected readings from the family therapy literature. Guided practice was incorporated as clinicians needed to become skilled in identifying family relationship problems and helping the family identify and resolve them. Participant recruitment began during week 5 of the training period to ensure that training cases were established prior to the close of the didactic section of training. Dr. Anderson supervised each clinician in two training cases to ensure that training concepts were absorbed and that there was treatment fidelity. The supervision of training cases included observation of therapy

sessions and weekly supervision for the duration of the study. Further, the clinicians providing SFT held monthly meetings throughout the study period to discuss cases. Three clinicians completed the agency training and were qualified to provide SFT. In addition, one licensed family therapist with extensive clinical experience was hired to provide SFT.

3.3 PROCEDURES FOR SAMPLING AND DATA COLLECTION

Participants of this study were children and their mothers, with mothers consecutively consenting for the study when initiating treatment for their children at a semi-rural community mental health clinic in New Kensington, Pennsylvania between January 1, 2009 and December 31, 2009. In order to be included in the study, mothers had to be the biological parent, adoptive parent, or grandparent, have custody of the child, and live with the child. Children had to be between the ages of five and seventeen to be eligible for the study. Families were excluded from the study if, upon initial assessment, clinicians determined that outpatient treatment was not appropriate for the presenting child.

Two hundred and seventy-seven new child treatment cases were initiated during the study period. Due to the eligibility criteria previously described, 150 mothers and children were eligible for the study and approached to participate. Of the eligible families, 36% of mothers and children (N=54) agreed to participate. Of the remaining families (N=96), mothers and children either refused participation (N=64) or could not be contacted (N=32). Of the 54 mothers and children who consented to the study, 43 (79.62%) completed the three-month follow-up and 39 (72.22%) completed the six-month follow-up (see Table 3).

Once families agreed to participate in the study, a trained interviewer explained the project to and obtained mothers' written informed consent and children's assent. The interviewer collected quantitative data at baseline, three months, and six months. The quantitative assessments were often conducted at the participant's home. Mothers

received twenty-five dollars and children received ten dollars for their participation in the study at each of the three time points.

Upon completion of the six-month assessment, the trained interviewer informed mothers participating in the study that they may be contacted to complete a semi-structured interview. In preparation for the interviews, this social work researcher, trained by the lead researcher, utilized a random numbers chart (Rubin & Babbie, 2005) to select a subsample of mothers to be contacted. This researcher attempted to contact thirty-six mothers in order to schedule and conduct interviews with twenty-seven participants. When the interview participants were contacted, they were reminded of the study and of their consent to be contacted for an additional semi-structured interview. Twenty-seven interviews were completed and all lasted between 25 and 90 minutes. Twenty-six of the interviews were completed in participant's homes and one was conducted at the community mental health clinic. All participants received fifty dollars for completing the semi-structured interview.

The in-depth interviews were non-leading and engagement focused, containing questions related to mother's perceptions of treatment for their own mental health needs as well as the family treatment. Additional questions examined why mothers can overcome barriers to care for their children but not for themselves (see Appendix B for semi-structured interview protocol). The interviews were digitally recorded and subsequently transcribed verbatim. This qualitative analysis will focus on exploring mothers' perceptions of treatment.

Treatment attendance in routine practice settings is variable (Merrill et al., 2003) and was variable in this case. However, inclusion criteria related to dose eligibility were

established to ensure study cases had received Structural Family Therapy. Criteria were established after consulting the literature. As previously noted, it is common for between 25 and 50 percent of consumers to refuse psychotherapy by failing to return to treatment after an initial intake or therapy (Garfield, 1994). Further, consumers in the routine treatment settings tend to get low doses, with an average of 4.3 sessions and median of three sessions (Hansen et al., 2002). In this study, families had to get at least two sessions of family therapy during the first twelve weeks to meet inclusion criteria. Administrative case records were examined in order to obtain participant dosage information and apply the dose eligibility inclusion criteria (see Appendix A). This resulted in an analytic sample of 31 families for the quantitative investigation. Of the 31 families who were dose eligible, 25 (81%) completed the three-month follow-up and 23 (74%) completed the six-month time point. Sixteen of the mothers who completed semi-structured interviews met dose eligibility inclusion criteria and were included in the qualitative analysis. While there are no established guidelines for an acceptable sample size in qualitative research, practice suggests that between 12 and 26 in-depth interviews are appropriate (Luborsky & Rubinstein, 1995). Therefore, this sample will likely yield saturation.

3.4 STUDY VARIABLES AND MEASUREMENT

Mothers participating in the study completed standardized assessments containing a battery of questionnaires. The assessments required approximately an hour to complete. Children also completed two questionnaires measuring their mental health symptomatology. Three standardized assessments occurred in equal intervals over a six-month time period. The current study analyzed two measures assessing mothers' mental health symptomatology; one measure assessing mothers' functioning; and three measures assessing children's mental health symptomatology. Mothers also completed a demographic information questionnaire at baseline that was analyzed descriptively and two treatment satisfaction measures across all three time points that were descriptively assessed and integrated with qualitative results to examine acceptability. Time was the independent variable of interest in this study.

3.4.1 Demographic Information

Demographic Information Questionnaire

The Self-reported Demographic Information Questionnaire, completed by mothers, included information on mothers' age, race, marital status, number of children in the home, education, employment status, and household income, as well as children's gender, age, and race.

3.4.2 Mothers' Mental Health Symptomatology

Beck Depression Inventory (BDI). The BDI was designed to detect the severity of 21 symptoms and attitudes correlated with depression in psychiatric patients; some of these symptoms included sadness, sleep problems, and loss of energy (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The BDI is scored by summing the 21 items. Each item

consists of a group of 4 statements rated from 0 to 3. The maximum total score is 63. General guidelines for cut-off scores indicate that respondents scoring 10 or above are experiencing depressive symptomatology (BDI Manual, 1987). Meta-analyses examining nine psychiatric samples and 15 non-psychiatric samples report consistently high alpha coefficients of .86 and .81, respectively (Beck, Steer, & Garbin, 1988). The BDI has also demonstrated strong concurrent validity. For example, the meta-analyses indicated a mean correlation of .72 for the BDI and clinician ratings for psychiatric patients and a correlation of .60 for the BDI and clinician ratings for non-psychiatric patients (Beck, Steer & Garbin, 1988).

Beck Anxiety Inventory (BAI). The Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988) is a 21-item scale, with each item describing a common symptom of anxiety. Respondents are asked to rate how much each symptom has bothered them over the past week on a four-point Likert scale ranging from 0 to 3. The items are summed to obtain a total score. The maximum total score is 63. A score of 22 or above indicates anxiety (Beck & Steer, 1990). The BAI was developed to reliably discriminate anxiety from depression while displaying convergent validity. It has demonstrated high internal consistency ($\alpha = 0.92$) and test-retest reliability over one week ($r(81) = 0.75$), and has been found to discriminate anxious diagnostic groups from non-anxious diagnostic groups. Further, the BAI was moderately correlated with the revised Hamilton Anxiety Rating Scale ($r(150) = 0.51$) and was only mildly correlated with the revised Hamilton Depression Rating Scale ($r(153) = 0.25$) (Beck, et al., 1988).

3.4.3 Mothers' Functioning

Sheehan Disability Scale (SDS). The Sheehan Disability Scale (Sheehan, 1983) is a 10 item scale that looks at the disruption that the respondent's and the respondent's child's problems cause in daily functioning. The scale consists of two parts, with part one assessing respondents' problems and part two assessing respondents' perceptions of their child's problems. The scale is scored by summing all items; higher scores indicate greater disruption of life while lower scores indicate less disruption with life. The SDS has demonstrated high internal consistency ($\alpha = 0.89$) and there is empirical support for the scale's construct validity as patients with psychiatric disorders had significantly higher impairment scores than well patients (Leon, et al., 1997). This study used an adaptation of the Sheehan Disability Scale that only included part one, assessing respondents' problems.

3.4.4 Children's Mental Health Symptomatology

Columbia Impairment Scale – Adult Version (CIS-A). The Columbia Impairment Scale – Adult Version (Bird, Shaffer, Fisher, Gould, Stagheza, Chen, & Hoven, 1993) is a 13-item instrument designed to provide a global assessment of children's impairment. Items are scored on a Likert scale ranging from 0 to 4, with 0 indicating "No problem" and 4 indicating "A very big problem." While the thirteen items tap into four major areas of functioning: interpersonal relations, certain broad areas of psychopathology, functioning at school or work, and use of leisure time, the instrument is scored by summing all items. Separate subscales are not generated as the authors found impairment was best represented as a single, total score instead of four separate scores for each dimension. The resulting sum scores indicate greater impairment with higher scores and less impairment

with lower scores. The threshold for impairment was found to be a score of 15 or higher. This version of scale, where a parent rates their child, is most reliable according to the source article; though there is some concern that parents experiencing mental health symptomatology may be more likely to rate their children as having greater impairment. When compared to the children's version, the CIS-A has demonstrated higher levels of validity.

Columbia Impairment Scale – Child Version (CIS-C). The Columbia Impairment Scale – Child Version (Bird, Shaffer, Fisher, Gould, Stagheza, Chen, & Hoven, 1993) is a 13-item self-report questionnaire designed to provide a global assessment of child impairment. Participants choose their response on a Likert scale from one to four with responses ranging from 0, no problem, to 4, a very big problem. The thirteen items tap into four major areas of functioning: interpersonal relations, certain broad areas of psychopathology, functioning at school or work, and use of leisure time; however separate subscales are not generated. A total score that best represents impairment is calculated by summing the point values for each item. A score of 15 or above indicates that the child is impaired. The CIS-C has demonstrated good test-retest reliability, with a reported intra class coefficient of .63. The discriminant validity was found to be significant ($p < 0.01$) for the CIS-C when comparing clinical and community subjects at two separate time points. The scale's demonstrated concurrent validity is sufficient but not ideal, with a Pearson correlation of $r = -.48$ (Bird et al., 1993).

Children's Depression Inventory (CDI) – Short Form. The Children's Depression Inventory – Short Form is used to evaluate child respondents' depressive symptomatology and consists of 10 multiple choice items. The items cover overt

symptoms of childhood depression such as sadness, anhedonia, suicidal ideation, and sleep and appetite disturbance. Each CDI item assesses one symptom by presenting three choices, scored from 0 to 2 in the direction of increasing psychopathology. Scores range from 0 to 20 with higher scores indicating more depressive symptomatology; however no cut-points have been reported. The CDI is suitable for children ages 6 to 17 and has been extensively used in social science research to effectively evaluate the externalizing and internalizing symptoms of depression (Kovacs, 1981). Psychometric assessments have demonstrated that the CDI has excellent test-retest reliability ($r = 0.87, p < 0.001$), criterion validity ($t(46) = 2.48, p < 0.02$) and concurrent validity ($r(26) = -0.64, p < 0.001$) (Saylor et al., 1984).

3.4.5 Treatment Satisfaction

Client Satisfaction Questionnaire (CSQ-8). This 8 item scale is derived from The Client Satisfaction Questionnaire (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) and designed to measure client satisfaction with services. The eight items were originally selected by mental health professionals from a number of items that could be related to client satisfaction and validated through factor analysis. The CSQ-8 is uni-dimensional, yielding a homogenous estimate for general satisfaction with services and the perceived value of the services received. Scores are generated by summing the items and can range from 8 to 32. Higher scores indicate greater satisfaction with services. The CSQ-8 has shown high internal consistency and has been correlated with change in respondent-reported symptoms, indicating that greater satisfaction with services was associated with greater symptoms reduction (Attkisson, Clifford & Zwick, 1982)

Charleston Psychiatric Outpatient Satisfaction Scale (CPO). The Charleston Psychiatric Outpatient Satisfaction Scale (Pellegrin, Stuart, Maree, Frueh, & Ballenger, 2001) is a 15-item scale assessing patient satisfaction with psychiatric services received. The scale includes statements about aspects of the service agency which respondents are asked to rate them on a Likert scale ranging from 1 to 5, where one is “poor” and 5 is “excellent.” The scale is scored by summing each item, except for two anchor questions that aren’t included in the total score. Higher scores indicate greater satisfaction with psychiatric services, while lower scores indicate less satisfaction. The CPO demonstrates high internal consistency ($\alpha = 0.87$) and its convergent validity has been supported by the significant correlation of all items with anchor items that measure overall satisfaction with care and likelihood of recommending the clinic to others (Pellegrin et al., 2001)

3.5 DATA ANALYSIS PLAN

3.5.1 Quantitative Data Analysis: Treatment Effectiveness

Quantitative data analysis was conducted using SPSS v. 18 and SAS v. 9.2. The data, originally entered in Microsoft Access v. 13, was imported directly into SPSS and cleaned. Data cleaned and scored in SPSS was imported in SAS. The SPSS Missing Values Analysis (MVA) module was used to identify any missing data. Questionnaires with more than 15% missing data were not tolerated and not used in analysis. For questionnaires missing 15% of data or less, mean substitution/imputation was utilized to fill the missing data point.

Preliminary Analysis. Preliminary analyses of the dependent variables addressing mothers' mental health symptomatology (BDI, BAI), mothers' functioning (SDS), children's mental health symptomatology (CIS-A, CIS-C, CDI) and treatment satisfaction (CSQ-8, CPO) were conducted to examine measures of central tendency and measures of dispersion. These analyses allowed this researcher to evaluate assumptions required for planned parametric tests, such as ANOVA. This researcher examined the distribution, skew, and kurtosis of the dependent variables to assess the need for transformations.

Descriptive Analysis. This researcher conducted descriptive analyses to characterize the sample's demographic characteristics, baseline symptom severity, and treatment dosage. Means and standard deviations were examined for continuous variables while frequency and percentages were examined for categorical variables. Differences in demographic variables and baseline symptom severity for participants completing all three time points and those lost to attrition were examined using *t*-tests or Chi-Squares.

Treatment Effectiveness. The primary analyses presented are One-way Repeated Measures Analysis of Variance (ANOVAs) conducted separately for each dependent variable measuring mothers' mental health symptomatology, maternal functioning, and child's mental health symptomatology, using time as a within-subjects factor. These analyses were conducted in SPSS v. 18. ANOVA models cannot tolerate missing data. That is, when either a mother or child is missing data for any time point, the case cannot be included in the analysis. In this study, 8 cases were missing from the six-month observation.

Analyses of dependent variables of interest were also conducted using random effects modeling in SAS 9.2. These models offer improvements on the ANOVA. First, they model the data for the 8 cases who did not participate across all three time points. Perhaps more importantly, they allow each subject to be treated as a random effect. Numerous authors argue that treating subjects as a random effect improves the generalizability, as well as strengthens the sensitivity of the model (Singer, 1998). In this study, data were not missing at random; missing cases represented attrition from the study. This somewhat weakens the applicability of these models to the data. The results of the more conservative ANOVAs and the results of random effects models are both presented.

One-Way Repeated Measures ANOVAs and Random Regression Models were also performed using a subsample mothers who were symptomatic at baseline. It is unlikely that mothers who were not symptomatic at baseline experienced much change in their symptomatology and could therefore bias results. For example, if, as hypothesized, SFT positively impacts mothers' depressive symptomatology and anxiety, the effect may

be diluted by mothers who were doing well at baseline and continued to do well over time. On the other hand, if mothers receiving SFT got worse over time, the mothers who were doing well at baseline and continued to do well over time may inflate the means. Mothers who met clinical cut-off scores of 10 or above on the BDI or 22 or above on the BAI were included in the subanalyses and mothers meeting clinical cut-offs for either symptomatology measure were included to assess change in functioning on the SDS. The children in this study were presenting for treatment and therefore expected to be symptomatic, so subanalyses for symptomatic children were not appropriate and not included.

Power Analysis. It is important to consider whether the sample size in the study described had adequate power to detect a statistically significant effect (Cohen, 1988). A Power Analysis was conducted using the G Power Analysis Program v. 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009) to examine the adequacy for the sample size used for the One-way Repeated Measures ANOVAs and random effects models.

3.5.2 Qualitative Data Analysis: Acceptability and Sustainability of Treatment

Thematic Analysis. The primary analytic approach for the qualitative data consisted of a theme-based content analysis of interview transcripts as outlined by Coffey and Atkinson (1996), Miles and Huberman (1984), and Strauss and Corbin (1990). Core categories pertaining to mothers' perceptions of family therapy were generated to address the acceptability and sustainability of family treatment within the community mental health setting. This researcher read and re-read the interview transcripts, which were transcribed verbatim, to gain a thorough and personal grasp of the data before beginning the thematic analysis. The analysis began with line-by-line, in vivo coding, an open coding strategy

that focused on minute aspects of the data and utilized participants' own language and meanings to represent their statements as much as possible (Strauss & Corbin, 1990). This led to the development of thematic categories, or axial codes, representing common themes that emerged. Finally, each category was intensely analyzed and further collapsed into core categories that represent most variation in mother's perceptions and behavior (Strauss, 1987). Throughout the coding process, this research engaged in memoing. Memoing allowed the researcher to explore connections between the core categories as well as relate the thematic analysis to the quantitative results. After this researcher independently coded the data, a second trained researcher reviewed the transcripts and memos. This researcher and the second trained researcher, who was the Principal Investigator of the original implementation study, met frequently to discuss identified themes and their connection to the quantitative data.

Treatment Satisfaction. Descriptive analyses of treatment satisfaction measures (CSQ-8, CPO) were conducted to assess measures of central tendency at the three-month and six-month time points. The results of these analyses were integrated with the thematic analysis in order to address the acceptability and sustainability of family therapy.

3.5.3 Interpretive Integration of Quantitative and Qualitative Data

After independently completing the quantitative and qualitative data analyses, core categories that emerged from mothers' semi-structured interviews were integrated with the quantitative findings in order to achieve greater understanding and insight about mothers' and children's collective experience receiving Structural Family Therapy within a semi-rural community mental health setting. The findings from each methodology were

used to develop increased clarity related to both the overall findings as well as the study implications.

4.0 RESULTS

Quantitative results, examining treatment effectiveness, are presented first, followed by the qualitative findings that explore acceptability and sustainability. The analysis is presented through descriptive statistics (i.e. measures of central tendency) and then reports the findings of the inferential methods (i.e. One-way Repeated Measures Analysis of Variance and Random Effects Models) to provide readers an understanding of the study variables of interest as well as treatment outcomes. Qualitative results are presented according to the core codes identified in the data with exemplar participant quotes highlighting appropriate thematic categories. Finally, quantitative and qualitative findings are synthesized and integrated in the discussion section, offering readers a thorough understanding of these mothers' perceptions of Structural Family Therapy.

Quantitative data collection was conducted by a trained researcher from Family Services of Western Pennsylvania. Electronic input of the quantitative data as well as the semi-structured interviews were conducted by this researcher. In addition, all coding and data analysis was completed by this researcher in order to ensure uniformity across the study design.

4.1 QUANTITATIVE RESULTS

In total, 31 baseline, 25 three month, and 23 six month interviews were completed. For all time points, data from the Beck Depression Inventory (BDI), the Beck Anxiety Inventory (BAI), the Sheehan Disability Scale (SDS), the Children's Depression Inventory (CDI), the Columbia Impairment Scale – Adult and Child versions (CIS-A and CIS-C), the Client Satisfaction Questionnaire (CSQ-8), and Charleston Psychiatric Outpatient Satisfaction Scale (CPO-C) were directly entered into Microsoft Access. Data from the demographic form was collected at baseline and entered directly into Microsoft Access as well. Data were then scored and transferred in SPSS v. 18 and SAS v. 9.2 for statistical analyses. Means, standard deviations, and ranges were calculated. In order to maximize the analytic sample, this researcher utilized mean imputation. Mean imputation is the most straightforward and commonly used method for handling missing data (Allison, 2001; Newton & Rudestam, 1999). Mean estimation is a conservative procedure, in that the mean distribution of the variable does not change. Table 2 provides the missing data information by measure and shows that overall, there was very little missing data. None of the measures were missing 15% or more of the total items, indicating that mean imputation was an appropriate technique.

Table 2. Missing Data Information by Measure

	Number of Missing Items	Items in Measure	Total Number of Items	Percent missing
Mothers' Symptomatology				
BDI (Baseline; N=31)	0	21	651	0

BDI (3 Months; N=25)	0	21	525	0
BDI (6 Months; N=23)	1	21	483	.002
BAI (Baseline; N=31)	0	21	651	0
BAI (3 Months; N=25)	1	21	525	.002
BAI (6 Months; N=23)	0	21	483	0
Mothers' Functioning				
SDS (Baseline; N=30)	4	3	90	.044
SDS (3 Months; N=25)	2	3	75	.027
SDS (6 Months; N=23)	0	3	69	0
Children's Symptomatology				
CIS-A (Baseline; N=31)	6	13	403	.015
CIS-A (3 Months; N=25)	3	13	325	.009
CIS-A (6 Months; N=23)	2	13	299	.007
CIS-C (Baseline; N=30)	1	13	390	.003
CIS-C (3 Months; N=25)	2	13	325	.006
CIS-C (6 Months; N=21)	0	13	273	0
CDI (Baseline; N=31)	0	10	310	0
CDI (3 Months; N=25)	0	10	250	0
CDI (6 Months; N=23)	0	10	230	0

4.1.1. Preliminary Analysis

Means, standard deviations, skew, and kurtosis statistics for all of the dependent variables were calculated and reported in Table 3. Statistics for the Beck Anxiety

Inventory, the Sheehan Disability Scale, the Columbia Impairment Scale – Adult Version, and the Columbia Impairment Scale – Child Version, were within the range necessary to meet the assumptions of normality and were appropriate for statistical analyses using planned parametric statistics. However, the Beck Depression Inventory and Child Depression Inventory had skews that did not meet the cut point of .80. The Beck Depression Inventory had a skew of .930 at the three-month time point and 1.09 at the six month time point. Therefore, a square root transformation was conducted, reducing the skews to acceptable -.058 and .280, respectively. The Child Depression Inventory had a skew of 1.64 at the three-month time point and 1.39 at the six-month time point. Again, a square root transformation was conducted in order to reduce the skews to .416 and .269. The transformed variables met the assumption of normality and were utilized for parametric tests. The treatment satisfaction measures were analyzed descriptively and therefore did not require evaluation of assumptions or transformation.

Table 3. Descriptive Statistics for Main Study Scales

Scale	Mean	SD	Skew	Kurtosis
Mothers' Symptomatology				
BDI				
Baseline (N=31)	16.94	12.71	.534	-.763
3 Month (N=25)	13.76	12.88	.930	.086
6 Month (N=23)	12.26	13.76	1.09	-.004
BAI				
Baseline (N=31)	15.06	12.58	.643	-.680
3 Month (N=25)	12.36	10.61	.559	-.849

6 Month (N=23)	9.48	9.27	.481	-.059
SDS				
Baseline (N=30)	11.87	9.62	.052	-1.60
3 Month (N= 25)	10.88	9.68	.550	-1.25
6 Month (N=23)	9.70	9.64	.849	-.339
Child Symptomatology				
CDI				
Baseline (N=31)	4.06	2.78	.317	-.857
3 Month (N=25)	3.60	3.56	1.64	2.27
6 Month (N=23)	3.68	4.17	1.38	1.08
CIS-A				
Baseline (N=31)	25.35	10.22	.251	-1.14
3 Month (N=25)	20.40	8.94	-.137	-.890
6 Month (N=23)	22.13	8.90	-.472	-.787
CIS-C				
Baseline (N=30)	20.47	7.82	-.107	-.091
3 Month (N=25)	18.68	7.93	.473	-.749
6 Month (N=21)	19.71	10.13	.490	-.385
Treatment Satisfaction				
CSQ-8				
Baseline (N=31)	25.23	6.07	-1.34	1.35
3 Month (N=25)	28.28	4.53	-2.93	1.95
6 Month (N=23)	27.91	3.80	-.949	1.42

CPO-C				
Baseline (N=31)	50.32	9.66	-.470	-.688
3 Month (N=25)	54.84	9.56	-.748	.049
6 Month (N=22)	51.41	12.46	-.610	-.408

4.1.2 Sample Characteristics and Descriptive Analysis

31 families met the inclusion criteria for the study, with mothers and their identified child completing the quantitative assessments for at least one time point. Demographic and clinical characteristics were descriptively analyzed and the findings are reported in this section.

Demographic Characteristics. Mothers' sampled had ages ranging from 23 to 64, with a mean age of 35.61 (SD=8.45). Twenty-six mothers participating in the study were white (83.9%) and five were African American (16.1%). Over half of the mothers sampled were married (n=14; 45.5%) or living with domestic partners (n=2; 6.5%), while seven were not married (22.6%), five were divorced (16.1%), two were legally separated (6.5%), and one was widowed (3.2%). Fifty-one percent of the participating mothers were high school graduates (n=10), had a GED equivalent (n=3), or had completed some college (n=3). Nineteen percent of mothers in the sample had less than a high school education (n=6) and another 19% completed an occupational or vocational technology program (n=6). Two mothers held an associate's degree (6.5%) and one mother was a college graduate (3.2%). The majority of mothers participating did not work outside of the home (n=19; 61.3%) and almost half of the mothers sampled reported household incomes of \$20,000 per year or less (n=15; 48.4%). Another 29% of mothers sampled

reported household incomes ranging from \$20,001 to \$30,000 per year (n=9). Five mothers (16.1%) reported household incomes between \$30,001 and \$50,000 per year and two mothers (6.5%) reported household incomes ranging from \$50,001 to \$75,000 per year. The number of children living in the home ranged from 1 to 8, with participating mothers having an average of 3 children in their households. Twenty-seven participants were the identified child's biological mothers (87.1%), while two were adoptive mothers (6.5%) and two were grandmothers (6.5%).

There were close to equal numbers of male and female children participating in the study. Sixteen of the children participating in the study were male (51.6%) and fifteen were female (48.4%). Children sampled had ages ranging from 5 to 16, with a mean age of 10 (SD=1.66). The majority of children sampled were younger, ages 6 to 12 (n=25; 80.6%), while six children were adolescents with ages ranging from 13 to 17 (19.4%). While there were almost equal numbers of males and females among the younger children in the sample, 66.7% of the adolescents were male (n=4). There were 21 white children (67.7%), 5 African American children (16.1%), and 5 biracial children (16.1%).

Table 4. Sample Demographic Characteristics

Characteristic		
Mother	<i>Mean</i>	<i>SD</i>
Age	35.61	8.45
Number of Children in Household	3.03	1.66
	<i>n(%)</i>	
Race:		
White	26 (83.9)	

African American	5 (16.1)
Education:	
Less than High School	6 (19.4)
GED	3 (9.7)
High School Graduate	10 (32.3)
Some College/No Degree	3 (9.7)
Associates Degree	2 (6.5)
Completed Occupational/Vo-Tech Program	6 (19.4)
College Graduate	1 (3.2)
Working Outside of the Home:	
Yes	12 (38.7)
No	19 (61.3)
Marital Status:	
Married	14 (45.2)
Domestic Partner	2 (6.5)
Never Married	7 (22.6)
Widowed	1 (3.2)
Legally Separated	2 (6.5)
Divorced	5 (16.1)
Household Income	
Less than \$5,000	4 (12.9)
\$5,001 - \$10,000	4 (12.9)

\$10,001 - \$15,000	4 (12.9)	
\$15,001 - \$20,000	3 (9.7)	
\$20,001 - \$30,000	9 (29)	
\$30,001 - \$40,000	4 (12.9)	
\$40,001 - \$50,000	1 (3.2)	
\$50,001 - \$75,000	2 (6.5)	
More than \$75,000	0 (0)	
Relationship to Identified Child		
Biological Mother	27 (87.1)	
Adoptive Mother	2 (6.5)	
Step Mother	0 (0)	
Grandmother	2 (6.5)	
Child		
	<i>Mean</i>	<i>SD</i>
Age	10.03	1.66
	<i>n (%)</i>	
6-12 years old:	25 (80.6)	
Male	12 (48)	
Female	13 (52)	
13-17 years old:	6 (19.4)	
Male	4 (66.7)	
Female	2 (33.3)	
Gender:		

Male	16 (51.6)
Female	15 (48.4)
Race:	
White	21 (67.7)
African American	5 (16.1)
Biracial	5 (16.1)

Clinical Characteristics. Descriptive analysis found that mothers exhibited high levels of mental health symptomatology at baseline. Mothers and children both indicated high levels of child impairment at baseline as well, while, on average, children were not experiencing depressive symptomatology at baseline.

Mothers' scores on the Beck Depression Inventory at baseline suggest that the majority of mothers (n=21; 68%) were experiencing depressive symptomatology, with 45% scoring in the moderate to severe range (see Table 5). The Beck Anxiety Inventory indicated that 25% of mothers experienced moderate to high anxiety at baseline (Beck & Steer, 1990). Eighty-one percent of mothers and 80% children completing the Columbia Impairment Scale at baseline indicated child impairment, defined as a score equal to or above 15 (Bird, et al., 1993). In fact, over a third of mothers rated their children's impairment at 30 or above (n=11; 35%), most likely indicating severe impairment. Children's scores on the CDI at baseline ranged from zero to nine, with 10 children scoring between 0 and 2, 10 children scoring between 3 and 5, and ten children scoring between 6 and 9. No further clarification can be made as no cut points are reported (Kovacs, 1992).

Descriptive analysis of treatment dosage found that families attended an average of 5.60 ($SD=.554$) family therapy sessions over the six month study period. While the number of family sessions received ranged from 2 to 16, the median number of family sessions was 5. Families attended more sessions during the first three month period, receiving an average of 3.81 ($SD=.366$) family sessions in the first twelve weeks.

Table 5. Sample Clinical Characteristics

Characteristics	<i>n (%)</i>
<i>(Level)</i>	
Mothers' Symptomatology at Baseline	
BDI Score	
0-9 (<i>minimal range</i>)	10 (32.3)
10-15 (<i>mild depression</i>)	7 (22.6)
16-29 (<i>moderate depression</i>)	8 (25.8)
30+ (<i>severe depression</i>)	6 (19.3)
BAI Score	
0-21 (<i>very low anxiety</i>)	23 (74.2)
22-35 (<i>moderate anxiety</i>)	5 (16.1)
36+ (<i>high anxiety</i>)	3 (9.7)
Children's Symptomatology at Baseline	
CIS-A Score	
0-14 (<i>no impairment</i>)	6 (19.4)
15+ (<i>impairment</i>)	25 (80.6)
CIS-C Score	

0-14 (<i>no impairment</i>)	6 (20)
15+ (<i>impairment</i>)	24 (80)
CDI Score	
0-2	10 (33.3)
3-5	10 (33.3)
6-9	10 (33.3)

Summary of Descriptive Analysis

In total, the descriptive statistics suggest that SFT is likely an appropriate intervention for this sample. The majority of mothers in this sample were experiencing depressive symptomatology and approximately one quarter reported moderate to high levels of anxiety when initiating family therapy. Further, 80% of children were impaired according to both mothers' ratings and children's self-ratings. SFT was specifically designed to treat families experiencing multiple problems and acknowledges the impact of the family relationship context as well as dysfunctional patterns of interactions on all family members' mental health needs. Therefore, the SFT model is likely equipped to address the concurrent mental health needs experienced by the mothers and children comprising this sample.

In addition, Minuchin and his colleagues specifically developed SFT for low-income families. More than three-quarters of families included in this study reported household incomes of \$30,000 or less, while almost one-half reported household incomes of \$20,000 or less. Considering that on average families had three children living in their

households, these families were living with limited financial resources. Again, this indicates that SFT offers an appropriate intervention for this population.

The adaptation for implementation of the SFT model aimed at making it more appropriate for single mothers is likely to be critical to treating families within this community mental health clinic. The sample was almost equally comprised of single mothers and mothers who were married or living with a domestic partner. The original SFT model was based primarily on the nuclear family and reinforced traditional gender roles. Further, the model described the formation of a parental coalition to regain control and authority. The adaptation encouraging active collaboration between therapists and mothers in order to set goals and identify inconsistencies is likely important for mothers in this sample to develop the support and confidence necessary to reestablish a functional organizational hierarchy within their families.

Finally, the means across all three time-points demonstrate trends supporting study hypotheses for mothers' mental health symptomatology and functioning. On average, scores for mothers' depressive symptomatology, anxiety, and functioning decreased, indicating improvement across all three outcome measures. However, mean scores across all three time points suggest mixed support for the study hypothesis related to children's mental health symptomatology. While average scores on all three children's measures decreased between the baseline and three month time period, they increased between the three and six month time period. A similar pattern emerged when examining the means over time for the two treatment satisfaction measures. This pattern may relate to dosage, which decreased from an average of 3.81 sessions from baseline to three months to 1.79 sessions from three to six months.

4.1.3 Attrition Analysis

Eight of the thirty-one families (25.8%) were lost to follow-up, resulting in a total of twenty-three families that completed all three time points. Independent samples *t*-tests and Chi Square tests were conducted to assess mean differences on demographic characteristics and symptom severity at baseline between mothers and children that completed the study and mothers and children that were lost to attrition. No significant differences were found on demographic characteristics or symptoms severity at baseline (see Table 6).

Table 6. Attrition Analysis

Demographic Characteristics	<i>t</i>	<i>df</i>	<i>p</i>
Mother:			
Age	.620	29	.540
# Children in Household	1.05	29	.301
	χ^2	<i>df</i>	<i>p</i>
Race	.105	1	.746
Education	11.50	6	.074
Employment Outside Home	.854	1	.355
Marital Status	9.74	5	.083
Relationship to Child	1.60	2	.450
Household Income	1.40	7	.985
Child:			
	<i>t</i>	<i>df</i>	<i>p</i>
Age	-.490	29	.628
	χ^2	<i>df</i>	<i>p</i>

Gender	2.36	1	.124
Race	.260	2	.878
Symptom Severity	<i>t</i>	<i>df</i>	<i>p</i>
Mothers' Symptomatology			
BDI	-.080	29	.937
BAI	0.208	29	.837
Child's Symptomatology			
CIS-A	.630	29	.534
CIS-C	-1.89	28	.070
CDI	-1.11	29	.276

4.1.4 Treatment Effectiveness

Results of the One-way Repeated Measures Analyses of Variance are reported first, followed by confirmatory analyses using Random Effects Modeling.

One-way Repeated Measures Analysis of Variance.

In order to assess treatment effectiveness, a series of one-way repeated measures analysis of variance were performed on mothers' mental health symptomatology (BDI, BAI), mothers' functioning (SDS), and children's mental health symptomatology (CIS-A, CIS-C, and CDI) as a function of time spent receiving Structural Family Therapy. The study participants were measured on each scale once every three months for six months (baseline, three months, and six months). The assumption of sphericity was tested for each analysis (see Table 7). If the assumption of sphericity was not met, the Greenhouse-Geisser adjustment was reported. In order to find the pattern of difference on scores

depending on time spent in Structural Family Therapy, post hoc pairwise comparisons were performed using the Bonferroni adjustment (see Table 7).

Mothers' Mental Health Symptomatology.

BDI

There was a significant difference on mothers' depression scores depending on time spent in Structural Family Therapy, $F(2,36) = 6.93, p = .003, \eta^2 = .278$. Post hoc pairwise comparisons using the Bonferroni adjustment found that the mothers' depression scores were significantly lower at six months compared to baseline, $p = .015$. The pattern of difference on mothers' depression scores at three months compared to baseline approached significance, $p = .056$. There were no significant differences when comparing mothers' three month and six month depression scores, $p = .939$.

BAI

There was a significant difference on mothers' anxiety scores depending on time spent in Structural Family Therapy, $F(2,34) = 6.44, p = .004, \eta^2 = .275$. Post hoc pairwise comparisons using the Bonferroni adjustment found that the mothers' anxiety scores were significantly lower at six months compared to baseline, $p = .027$. The pattern of difference on mothers' anxiety scores at three months compared to baseline was marginally significant, $p = .052$. There were no other significant differences, $p > .49$.

Mothers' Functioning.

SDS

There was no significant difference on maternal functioning depending on time spent in Structural Family Therapy, $F(1.32,23.66) = 2.72, p = .104, \eta^2 = .131$. Post hoc

pairwise comparisons using the Bonferroni adjustment found no significant differences, with all p values greater than .24.

Children's Mental Health Symptomatology.

CIS-A

There was a significant difference on mothers' rating of their children's impairment depending on time spent in Structural Family Therapy, $F(2, 42) = 8.42$, $p = .001$, $\eta^2 = .286$. Post hoc pairwise comparisons using the Bonferroni adjustment found that the mothers' ratings of their children's impairment significantly improved when comparing baseline to three months, $p = .003$. There were no other significant differences and all p values were greater than .10.

CIS-C

There was no significant difference on children's rating of their impairment depending on time spent in Structural Family Therapy $F(1.43, 22.89)$, $p = .771$, $\eta^2 = .016$. Post hoc pairwise comparisons using the Bonferroni adjustment found no significant differences, with all p values greater than .99.

CDI

There was no significant difference on children's rating of their depressive symptomatology depending on time spent in Structural Family Therapy $F(2, 34) = .402$, $p = .672$, $\eta^2 = .023$. Post hoc pairwise comparisons using the Bonferroni adjustment found no significant differences, with all p values greater than .99.

Table 7. One-Way Repeated Measures ANOVA Results (N=23)

Measure	BL	3 Mo	6 Mo	Mauchly's <i>W</i>	<i>p</i>	<i>F</i>	<i>df</i>	<i>p</i>	η^2
	<i>Mean</i>	<i>Mean</i>	<i>Mean</i>						
	(<i>SD</i>)	(<i>SD</i>)	(<i>SD</i>)						
Mothers'									
Symptomatology									
BDI	16.94 _a	13.76 _a	12.26 _b	.864	.288	5.94	2	.003*	.278
	(12.71)	(12.88)	(13.76)						
BAI	15.06 _a	12.36 _a	9.48 _b	.791	.154	6.44	2	.004*	.275
	(12.88)	(10.61)	(9.27)						
Mothers' Functioning									
SDS	11.87 _a	10.88 _a	9.70 _a	.479	.002 τ	2.72	1.32	.104	.131
	(9.62)	(9.68)	(9.63)						
Children's Mental Health									
Symptomatology									
CIS-A	25.35 _a	20.40 _b	22.13 _a	.968	.773	6.27	2	.005*	.270
	(10.22)	(8.94)	(8.99)						
CIS-C	20.47 _a	18.68 _a	19.71 _a	.602	.022 τ	.262	1.43	.771	.016
	(7.82)	(7.93)	(10.13)						
CDI	4.06 _a	3.60 _a	3.68 _a	.985	.890	.402	2	.672	.023
	(2.78)	(3.56)	(4.17)						

* $p < .05$; τ indicates violation of sphericity assumption and Greenhouse-Geisser adjusted test statistics are reported; _a indicates no change from baseline, _b indicates statistically significant change from baseline

The results of the One-way Repeated Measures ANOVAs, presented in Table 7 demonstrate significant differences on mothers' mental health symptomatology and mothers' ratings for their children's impairment depending on time spent in family therapy. Mothers' depressive symptomatology and anxiety significantly decreased from baseline to six months. Mothers' depressive symptomatology and anxiety decreased between baseline and three months as well, approaching statistical significance with respective p-values of .056 and .052. The respective effect sizes of .278 for improvement in depressive symptomatology and .275 for improvement in anxiety are consistent with findings from Shadish and colleagues (1993) meta-analysis, indicating that effects sizes for systemic family therapy were .25-.26 for child outcomes.

It is common for depression to naturally remit over time. Therefore, it is important to consider whether or not time spent in SFT affected mothers' depressive symptomatology or whether the change could be attributed to the natural course of depression. A meta-analysis of 19 studies of adult depression involving 221 subjects in wait list control groups found that on average, these participants' BDI scores improved 15.7% over an average of 8.68 sessions (Posternak & Miller, 2001). In the current study, mothers' BDI scores improved 27.63% over 5.60 family therapy sessions. This suggests that receiving SFT impacted mothers' depressive symptomatology over time above and beyond what would be expected for natural remittance.

Mothers' ratings of their children's impairment significantly decreased from baseline to three months. No other significant differences were found, and, in fact, the mothers' mean impairment rating slightly increased between three and six months. The effect size for the improvement in mothers' rating of their children's impairment was .27,

again consistent with an effect size of .25 reported in a meta-analysis of systemic therapy examining child behavioral outcomes (Shadish et al., 1993). Findings also indicate no significant differences on mothers' functioning or children's self-rated mental health symptomatology depending on time spent in family therapy.

Random Effects Modeling

Random effects models confirm the findings of the One-way Repeated Measures ANOVAs (see Table 8). Time in family therapy had a significant effect on mothers' mental health symptomatology (BDI, BAI) and mothers' ratings of their children's impairment (CIS-A), but time did not have a significant effect on maternal functioning (SDS) or children's self-reported mental health symptomatology (CIS-S, CDI). Separate Random Effects Models were conducted for each dependent variable, and Table 8 reports the beta coefficient of time for each model.

Table 8. Random Effects Modeling Results (N=31)

	β	SE	t	P
Mothers' Symptomatology				
BDI	-.127	.050	-2.53	.015*
BAI	-.800	.330	-2.40	.021*
Mothers' Functioning				
SDS	-.478	.309	-1.55	.129
Children's Symptomatology				
CIS-A	-.067	.288	-2.32	.025*
CIS-C	.026	.263	.100	.921
CDI	-.038	.036	-1.06	.294

* $p < .05$

4.1.5 Treatment Effectiveness for Mothers Symptomatic at Baseline

One-Way Repeated Measures ANOVA for Symptomatic Cases Only

Subanalyses of treatment effectiveness for those mothers who were experiencing mental health symptomatology at baseline, and therefore predicted to improve with time spent in family therapy, were conducted through a series of one-way repeated measures ANOVAs. Mothers who scored a 10 or above on the BDI ($n=21$), 22 or above on the BAI ($n=8$) were included for analyses. In addition, mothers who met the clinical cut-offs for either symptomatology were included in the analysis to assess functioning. ANOVAs were performed on mothers' mental health symptomatology (BDI, BAI) and functioning (SDS) as a function of time spent in family therapy. The assumption of sphericity was tested for each analysis (see Table 9). If the assumption of sphericity was not met, the Greenhouse-Geisser adjustment was reported. In order to find the pattern of difference on scores depending on time spent in Structural Family Therapy, post hoc pairwise comparisons were performed using the Bonferroni adjustment.

Mothers' Mental Health Symptomatology.

BDI

There was a significant difference on depression scores for mothers who were symptomatic at baseline depending on time spent in Structural Family Therapy, $F(2, 20) = 11.48, p < .001, \eta^2 = .534$. Post hoc pairwise comparisons using the Bonferroni adjustment found that mothers' depression scores were significantly lower at three months compared to baseline, $p = .008$ and significantly lower at six months compared to

baseline, $p = .016$. There were no significant differences when comparing mothers' three month and six month depression scores, $p = 1.00$.

BAI

There was a significant difference on mothers' anxiety scores depending on time spent in Structural Family Therapy, $F(2,10) = 35.03$, $p < .001$, $\eta^2 = .875$. Post hoc pairwise comparisons using the Bonferroni adjustment found that the mothers' anxiety scores were significantly lower at three months compared to baseline, $p = .008$, and significantly lower at six months compared to baseline, $p = .001$. There were no significant differences between mothers' anxiety scores at three months and six months, $p = .067$.

Mothers' Functioning.

SDS

There was a significant difference on mothers' functioning scores depending on time spent in Structural Family Therapy, $F(1.37,23.30) = 6.37$, $p = .004$, $\eta^2 = .273$. Post hoc pairwise comparisons using the Bonferroni adjustment found that mothers' functioning scores were significantly lower at six months compared to baseline, $p = .048$. There were no other significant differences, with p values greater than .061.

Table 9. One-way Repeated Measures ANOVAs Results for Symptomatic Mothers

Measure	BL	3 Mo	6 Mo	Mauchly's W	p	F	df	p	η^2
	<i>Mean</i>	<i>Mean</i>	<i>Mean</i>						
	<i>(SD)</i>	<i>(SD)</i>	<i>(SD)</i>						
Mothers'									
Symptomatology									

BDI (N=14)	23.10 _a (2.32)	19.19 _b (3.23)	18.14 _b (3.92)	.639	.134	11.48	2	<.001*	.534
BAI (N=6)	32.33 _a (2.81)	20.67 _b (3.84)	12.33 _b (4.18)	.957	.915	35.03	2	<.001*	.875
Mothers' Functioning									
SDS (N=20)	17.83 _a (1.97)	13.67 _a (2.24)	11.56 _b (2.30)	9.78	.008 τ	8.57	2	.004*	.588

* $p < .05$; τ indicates violation of sphericity assumption and Greenhouse-Geisser adjusted test statistics are reported; _a indicates no change from baseline, _b indicates statistically significant change from baseline

The subanalyses of mothers who were symptomatic at baseline confirm that mothers' mental health symptomatology significantly improved with time spent in Structural Family Therapy. The results of the subanalyses provide added confidence that SFT impacted mother's symptomatology above and beyond nature remittance over time, as the effect sizes were much larger: .534 for depressive symptomatology and .875 for anxiety. Further, symptomatic mothers' functioning significantly improved with time spent in Structural Family Therapy. Symptomatic mothers mean functional impairment at baseline, 17.83, was quite a bit larger than the full sample's mean functional impairment at baseline of 11.87. This suggests that the dual impact of children's behavioral challenges and their own mental health needs negatively affected mothers' ability to function. It is likely that SFT model's concurrent focus on mothers' and children's needs as well as restructuring dysfunctional patterns of transaction improved overall family functioning and subsequently improved functioning for symptomatic mothers.

Random Effects Modeling for Symptomatic Cases Only

Again, the random effects models confirm the findings of the One-way Repeated Measures ANOVAs for symptomatic mothers' mental health symptomatology, but not for mothers' functioning. Random effects modeling suggests that time spent in Structural Family Therapy had a significant effect on mothers' depressive symptomatology and anxiety. The effect of time spent in family therapy is greater for the subsample of symptomatic mothers, as evidenced by the coefficient of time for each model. For each unit of time, mothers' depressive symptomatology and anxiety decreased at a greater rate than it did when examining the results for the full sample (see Table 10). Random effects modeling did not find that time spent in Structural Family Therapy impacted mothers' functioning. It may be that the ANOVA overestimated the change in maternal functioning due to its inability to handle missing data. Though raw mean differences still suggest that symptomatic mothers may have had greater impairment in functioning than the full sample at baseline and that the means decreased over time, indicated that future work should continue to explore the impact of family therapy on maternal functioning.

Table 10. Random Effects Modeling Results for Symptomatic Mothers

	β	<i>SE</i>	<i>t</i>	<i>P</i>
Mothers' Mental Health Symptomatology				
BDI (N=21)	-.197	.071	-2.76	.009*
BAI (N=8)	-1.38	.510	-2.71	.012*
Mothers' Functioning				
SDS (N=29)	-.721	.404	-1.79	.084

4.1.6 Results of Power Analysis

The results of power analyses using G Power v. 3.1 (Faul, Erdfelder, Buchner & Land, 2009) indicate that for a One-way Repeated Measures ANOVA, a sample size of 23 is adequate to detect a relatively small effect (.30) with the required power level, .80, for a two-tailed distribution. Results also suggest that a samples size of 31 is adequate to detect a relatively small effect (.30) at the .80 power level for a two-tailed distribution with Random Effects Modeling. These findings indicate that the current study had a sufficient number of subjects to detect a relatively small effect, allowing for accurate rejection of the null hypothesis 80% of the time given the effect is really there.

4.1.7 Summary of Quantitative Results

The results of this quantitative analysis suggest some support for the study hypotheses. As predicted, mothers receiving Structural Family Therapy within the community setting experienced improvement in their mental health symptomatology. When assessing the full sample, mothers' depressive symptomatology and mothers' anxiety significantly improved as a function of their time spent in Structural Family Therapy. However, results suggest that mothers' functioning did not significantly improve with time spent in family treatment. Mothers who were symptomatic at baseline experienced significant improvement of depressive symptomatology and anxiety, with much larger effect sizes. There were mixed results regarding symptomatic mothers' functioning, with One-way Repeated Measures ANOVA suggesting that maternal functioning significantly improved with time spent in Structural Family Therapy and Random Effects Modeling indicating that time in Structural Family Therapy did not affect maternal functioning. An examination of the means suggests symptomatic mothers

experienced greater impairments in functioning at baseline and greater improvement in functioning over time than the full sample. Future work with larger sample sizes should continue to examine the potential impact of family therapy on maternal functioning.

Further, contrary to prediction, children receiving Structural Family Therapy did not experience improvement in their self-reported mental health symptomatology. Children's depressive symptomatology and their self-rated impairment did not significantly improve depending on their time spent in Structural Family Therapy. However, mothers' ratings of their children's impairment improved significantly as a function of time spent in family therapy. Children may not have improved due to their high level of impairment at baseline. Even with significant improvement over the study period, mothers' ratings indicated their children were still impaired at the six-month time point. In addition, the relatively low session dosage, an average of less than one session a month over the six month study period, is not unusual for the community mental health setting but a stark departure from the efficacy studies of family treatment (Hansen et al., 2002; Shadish, 1993). This may have impacted children's improvement. It is likely these children simply did not get enough therapy to address their severe impairment. Further, the low dosage calls into question the sustainability implementing Structural Family Therapy, or any type of model based care for that matter, within community mental health settings. Since therapists are seeing families on such an infrequent basis, it is likely difficult for them to implement core principles of the SFT model. For example, it may be challenging for clinicians to establish the trust and rapport necessary to complete the joining process, in which therapists enter the family system and ultimately change patterns of interaction believed to contribute to the child's presenting problems. Further,

dosage aside, family therapy is difficult to practice, even for experienced therapists. Even though SFT was created to be easily trained and administered by para-professionals, it may be that well-educated, licensed clinicians felt uncomfortable or lacked confidence when working with multiple family members at once, especially if their background did not include group or family work. In that case, it may be that families were not actually receiving core elements of SFT model necessary to facilitate change.

To gain a more in depth understanding of mothers' experiences with Structural Family Therapy, its acceptability to them and its sustainability, we turn now to the qualitative results.

4.2 QUALITATIVE RESULTS

A total of sixteen mothers whose families received Structural Family Therapy when initiating treatment for a child completed semi-structured interviews after finishing the quantitative portion of the study.

This researcher utilized a random numbers chart (Rubin & Babbie, 2005) to select a subsample of mothers who consented to study participation, including the possibility of a semi-structured interview. This researcher attempted to contact 36 participants in order to reach 27 mothers. Out of the 36 selected, five telephones had been disconnected and four could not be reached. The 27 mothers contacted by this researcher were reminded of the study, and of their consent to be contacted for an additional interview. All 27 mothers who could be reached chose to participate and scheduled a time for their interview with this researcher, who conducted all of the interviews. All but one of the interviews took place in participants' homes and one was conducted at the community mental health clinic. All of the interviews lasted between 30 minutes and 90 minutes. Participants received fifty dollars for their time. Of the 27 mothers interviewed, 16 met the dose eligibility criteria necessary for inclusion in this study and had received at least two Structural Family Therapy sessions over during their first three months in treatment. The thematic analysis was limited to those 16 interviews.

The interviews were digitally recorded and subsequently transcribed verbatim. A trained transcriptionist affiliated with the University transcribed the interviews. The semi-structured interviews were non-leading and engagement focused in order to limit investigator bias and experimenter effect. The interviews contained questions related to mothers' perceptions of treatment their own mental health needs as well as their

children's (see Appendix B). This qualitative analysis focused on mothers' perceptions of family treatment in order to explore its acceptability and sustainability for mothers and children receiving care in the community mental health setting.

4.2.1 Thematic Analysis

The primary analytic approach utilized was a thematic analysis of the interview transcriptions. To conduct thematic analysis, digital recordings of the interviews were transcribed verbatim. This researcher read each interview multiple times to check for errors and develop an intimate grasp of the content. These transcripts subsequently underwent the process of open coding, in which this researcher identified themes from the raw data (Strauss & Corbin, 1998). In vivo (line-by-line) coding, a form of open coding, was utilized by this researcher in order to represent codes with participants' own language and meanings whenever possible (Strauss & Corbin, 1990). After in vivo coding was completed, this researcher began separating and sorting the open coded passages into thematic categories, or axial codes. Open coded passages were reviewed and related passages were grouped together to form axial codes. Next, the axial codes were further refined. This process led to the development of core categories with broader applicability. The passages identified through open coding were reviewed in relation to the core codes and interpreted and connected through memo writing and on-going dialogue with a second reader. The second reader served as the Principal Investigator of the original implementation study and therefore had an in-depth understanding of the Structural Family Therapy Model as well as the practice setting. The second reader read all of the transcripts, as well as this researcher's memos. Meetings were held to discuss the thematic analysis and its broader connection to the quantitative findings.

Thematic analysis of the sixteen interviews with mothers whose families received Structural Family Therapy in a community mental health setting yielded three core categories: 1) Reasons for Seeking Family Therapy; 2) Reactions to Family Therapy; and 3) Implementation of Family Therapy. These themes are distinct, yet inter-connected and discussed in detail in the following sections. In addition to summarizing, describing, and interpreting the themes, statements made by the mothers that reflect the themes are reported. To protect anonymity, study identification numbers are utilized in the study to represent participants.

Table 11. Results of Thematic Analysis

Core Category	Axial Codes	Definition
1) Reasons for Seeking Family Therapy		Participant experiences with a child exhibiting behavioral health problems and the factors leading mothers to seek family therapy for their child.
	1.1) Child's Severe Behavioral Health Problems	Participant experiences with severe child behavioral health problems that were above parent(s)' ability to handle and threatened child's well-being (i.e. suicidal ideation; threat of expulsion/suspension)
	1.2) Life Like Rollercoaster	Participant experiences of never knowing what's going to happen day to day, lack of consistency, and constant ups and downs.
	1.3) Mom's High Stress	Participant belief that taking care of a child with behavioral health needs contributes to mothers' feelings of stress, mental health symptomatology (overwhelmed; drained;

		didn't know what else to do anymore)
	1.4) Mom's Mental Health History	Participant experiences with their own mental health problems, diagnosis, and treatment
2) Reactions to Family Therapy		Participant experiences receiving family therapy within a community mental health setting and the way in which it impacted child and maternal outcomes.
	2.1) Parental Coping Strategies	Participant experiences of learning and using coping strategies to deal with child's behavior or engage in self-care.
	2.2) Insight	Participant experiences of gaining insight to their child's behavioral health needs, leading to changes in patterns of interaction among family members.
	2.3) Family Dynamic	Participant perceptions of changing family dynamics (i.e. restored organizational hierarchy, discontinued dysfunctional patterns of interaction).
	2.4) Gateway to Individual Treatment	Participant experiences with family therapy provided level of comfort with services and understanding of their own mental health needs that led to pursuit of individual therapy.
	2.5) Child Improvement	Participant perceptions of positive changes in child's behavior
	2.6) Father Not Involved	Participant experiences of initiating strategies and principles of family therapy without support or involvement of father.
3) Implementation of Family Therapy		Participant perceptions related to model

3.1) Language	implementation and fidelity Participants' use of language exemplifying principles and central tenets of family treatment.
3.2) Child v. Family	Participants' perception that therapy is for child even though mothers are asked about their own feelings and included in therapy sessions.
3.3) Inconsistency	Participants' perception that they did not get enough treatment.
3.4) It's Not You, It's My Child	Participants' experiences of family therapy as a stepping stone to more intensive/restrictive interventions for their children.

Reasons for Seeking Family Therapy. Mothers' reasons for seeking family therapy when initiating treatment for their child is one of the core categories that emerged from the qualitative interviews. The mothers discussed severe behavioral health needs experienced by their children and how addressing these needs exceeded their abilities as parents. Participants felt that they couldn't do anything more to help their children. Participants expressed a connection between their children's behavioral health and their own feelings of stress and their ability to function effectively as a parent. Participants felt that their child's impairment directly impacted their feelings, frequently describing themselves as "over-stressed" and "overwhelmed" by their child's needs. Participants also acknowledged a high level of chaos in their lives, describing their day-to-day existence as a rollercoaster ride, filled with ups and downs. Participants described this constant turmoil as a cause of tension and anxiety. Participants also discussed their own history with mental health needs and mental health treatment.

Questions asked during the qualitative interview to gain information about families' reasons for seeking therapy included: 1) Could you please tell me the story of what led you to seek services for your child?; 2) What was going on in your own life at that time; and 3) What was going on in your family's life at that time?.

Child's Severe Behavior Problems. Most participants believed that their child's behavior had reached a level that threatened his or her well-being. Participants stated that these severe behavioral health needs were an impetus for initiating treatment. Participants identified suicidal ideation and school related sanctions, such as expulsion and suspension as the most common catalysts for seeking care. One participant stated:

"...and when she tried to kill herself was my last straw. So, that's why we started seeking help, cause she was having suicidal thoughts. So I called Family Services just to see what to do and they said, you know, bring her in, she should be seen" (1102).

Another participant shared:

"...it came down to the point that they told me if I didn't do something about it they were expelling her...and she's only five. She just turned six yesterday. So...I actually had to go get her from the school one day because she had hit the principal and kicking the teacher like when I got to the school the principal's neck was all red from [child] hitting her. The teacher's leg had already bruised from [child] kicking her" (1154).

Participants felt that they could no longer manage their child's behavioral health needs without help. Participants endorsed these feelings of helplessness as a primary reason to seek help. One participant stated:

"...you know, these problems started...and we cannot help him...he's not, you know, he's beyond what our capabilities as parents are, so we sought help for him, yes" (1104).

Similarly, one participant explained:

"Well, she was drug addicted to begin with at birth...and I was told to expect behaviors to worsen as she gets older and believe me, they did.

She was to the point where she was stealing, she wasn't following house rules, she was abusing her siblings, and not doing well in school, argumentative with teachers, she actually got thrown out of school a couple of times, she got thrown off the bus to go to school and I've had to transport her back and forth...and I was just at the point where I didn't know what to do but take her to get her some help" (1115).

Participants expressed that their child's severe mental health needs in conjunction with their inability to effectively deal with these needs increased their own stress levels and influenced their decision to seek family therapy.

Mothers' High Stress as a Result of Child Behaviors. Participants suggested that they experienced high stress and mental health symptomatology as a result of their child's behavior problems. Most participants endorsed high stress levels when describing their own lives at the time they decided to seek help for their children. Participants discussed feeling, "...a lot of tension" (1102), "like I had the world on my shoulder" (1113) and "overwhelmed" (1115).

Participants believed that their child's behavior impacted their own mental health. One participant stated, "...but I'll tell you what, these trials and tribulations with this child are going to put me in the 'nut ward'" (1127). Many participants described experiencing mental health symptomatology. A participant explained:

"You know, it's very hard with everything that's gone on. Um, my husband and I were walking on eggshells, trying to figure out how to deal with her, how to keep everyone safe, what was going on, what started it, where did it come from...I would have moments, where, for no reason, I would just start bawling, and I still, it's like, what am I crying about? I don't even know" (1130).

These feelings could impact participants' decision to initiate family treatment. When discussing her decision to choose family therapy, one married participant who had moderate depressive symptomatology at baseline stated:

“Well, I’m extremely over-stressed and overwhelmed with everything in my life having all these teenage boys and my oldest son has been a problem...So, by the time I got to this Family Services, I was just drained. I just didn’t know what else to do anymore. And I felt there was absolutely no way I could help my kids because I was a mess...So, I was starting to worry about myself...we were definitely overwhelmed” (1114).

While mothers identified their own stress and mental health symptomatology as stemming from their children’s behavioral challenges, it is likely that they also believed family therapy offered a value-added approach that would address their own needs. For instance, if mothers felt that getting help for their children would be enough to ameliorate their own problems, they would have initiated individual child treatment. Qualitative data suggests that mothers’ chaotic lives and their own mental health history also influenced their decision to seek family therapy.

Life Like Rollercoaster. Participants often stated that their lives were like “constant rollercoaster[s].” One mother shared, “My life is always like that. Up and down, up and down. I always have, like, chaos and things going on and stuff that I have a hard time dealing with” (1137). Some participants described their children’s problems as further exacerbating the chaos they typically experienced. One participant explained, “But how can you not be bipolar dealing with this situation [child’s behavioral health]...but this has magnified my rollercoaster ride” (1130).

Participants’ described lifestyles that normalized a level of chaos and, in fact, it is likely that mothers developed resiliency and were able to manage despite a lot of flux. However, it may be that the constant turmoil experienced by these mothers, combined with the immediate concerns associated with their children’s behavior health and their

perceived inability to effectively manage their children, contributed to participants' decision to choose family treatment.

Mothers' Mental Health and Treatment History. Ten of the sixteen participants shared that they had a mental health diagnosis themselves. Mothers believed that their diagnosis stemmed from their stress level, often due to parenting responsibilities. One participant stated:

“Yeah, I’ve had a long history of anxiety and...I wouldn’t say depression, more anxiety...I used to have panic attacks pretty regular, um, I was a single mom for quite some time. Um, I’ve been through a lot in my life from way back...I could probably write a book” (1114).

Despite acknowledging their mental health diagnoses, participants indicated that their mental health needs were unmet. Some mothers were given medication to address their mental health needs, but did not comply with the prescribed treatment regimen. For example, one participant stated:

“Well, I’m depressed anyway. I don’t have my medication so that plays a big part in it. I work all the time. I suffer from depression, just me being stressed out in general, with him, and not having my medication, and working all the time, and money...I mean, I went to the doctor. They had me on medicine and then, of course, I quit taking it again. I don’t know...I really haven’t worked through any of it yet” (1110).

Participants acknowledged that barriers prevented them from seeking individual treatment. When discussing her decision not to seek individual treatment, one participant explained:

“I was on medication for a long time. I was diagnosed as bipolar. Um, I was diagnosed as bipolar, manic depressive, so was my mother, um for a long time. I went off the medication on my own...When my mother got ill, my family doctor put me back on medication. But after a couple of months of being on it, he wouldn’t prescribe it any longer and he said you have to go to a therapist. Well, here’s the deal. I need to go to an allergist too. I need to go to a family doctor. I mean I don’t make appointments for myself. I’m lucky I can get in once a year to get my

teeth cleaned” (1150).

Another participant described feeling apprehension about seeking individual services, stating:

“Like, I knew when the doctor gave me medicine and told me that I was depressed that I needed to start taking depression medicine... I know...I just haven’t got up enough nerve to get a counselor yet...” (1154).

Mothers acknowledged their mental health needs, but largely did not seek individual therapy. Some mothers reported trying to address their mental health needs with medication; though indicated non-compliance with treatment. Further, mothers indicated that individual treatment presented barriers, such as stigma and role strain. It could be that family therapy offered mothers an acceptable way to address their own needs by lessening the identified barriers. Mothers are primary caregivers and the social construction of motherhood in our society places the brunt of parenting responsibilities on mothers. Therefore mothers put their children’s needs ahead of their own. Family therapy allows mothers to address their own needs while taking care of their children’s needs and meeting the social expectations of motherhood. Additionally, as mothers are expected to seek care for their children, they are less likely to experience stigma if their service involvement revolves around their children as the identified patient.

Mothers’ mental health history also suggests that children’s behavioral challenges may have a genetic component. Family therapy offers an important avenue for understanding family history and the ways in which the mental health needs of multiple effected family members can be managed and understood by the family system. Though in some cases, the hereditary nature of mental health needs indicates an organic problem that requires intervention above and beyond what can be provided in family therapy. That

said, it is critical for clinicians to have an awareness of family history, the skill level to accurately diagnose, and the ability to identify the most appropriate intervention for families on a case-by-case basis.

Reactions to Family Therapy. Reactions to Family Therapy emerged as a core category and represents the main thrust of the thematic analysis. Participants' believed that family therapy addressed two of the primary reasons they initially sought treatment, their children's severe behavior and their own challenges managing that behavior. Mothers indicated that family therapy provided parental coping strategies that helped them more effectively manage their children's behavior and encouraged them to engage in self-care. Family therapy was also endorsed as increasing mothers' insight to their children's behavioral health needs and improving their family's connection and communication. Mothers' reactions also suggest that family therapy served as a gateway to individual treatment and that the lack of fathers' involvement impacted their treatment experiences.

As the semi-structured interviews with a randomly selected subsample of mothers who received Structural Family Therapy were non-leading and engagement focused in order to prevent interviewer bias and socially desirable responses, participants' reaction to family therapy emerged from questions throughout the interview protocol.

Child Improvement. Nine of the sixteen participants believed family therapy led to improvement in their children's behavioral health. Mothers described changes they observed in their children's mental health symptomatology after initiating family therapy.

One mother shared:

“Yeah, we were able to have a good time. We were able to laugh and smile and just be goofy. Like [presenting child] was always a goofy kid and he turned into this walking-on-needles kind of kid. Um, so we started seeing a lot of that coming back...” (1114).

Some mothers reported sensing an overall change in their home as a result of their child's improvement. For example, one participant stated:

"After the first two weeks of her having services I could see a big change in the house. She would come in without an attitude. She would say please and thank you...She keeps her bedroom clean now. Another issue with her was she hated to bathe. Well now she's in that tub every night at 8:00 ready to bathe, washing her hair and getting ready for school and it's a good thing. Things are turning around." (1115).

Mothers indicated that family therapy not only led to an improvement in their children's behavior, but equipped them with parental coping strategies that further supported behavioral management. However, it may be that mothers' improvement influenced their perceptions of their children. It is likely that if mothers were able to more effectively manage their children's behavior and restore their families' organizational hierarchy, they may have misinterpreted an improvement in family functioning as an improvement in the presenting children's symptomatology.

Parental Coping Strategies. Participants believed that family therapy helped them to develop coping strategies necessary to effectively address their child's behavior problems. Participants felt that their own stress levels and their family functioning improved as a result of these coping strategies. Participants endorsed core principles of family therapy when describing reasons their ability to cope with their child's illness improved. For example, one participated stated:

"It definitely helped me. I mean, it lowered some of my stress. I no longer felt overwhelmed. Um, because of the things that I learnt to do to, you know, control the situation in the house. Like I said, the physical aggression was one of the biggest things in the house and thank goodness that totally stopped, so..." (1111).

Participants described learning strategies related to re-establishing the family's organizational hierarchy, specifically regaining their parental authority. Participants described specific situations where they applied a strategy learned through family therapy. One participant shared:

“...cause she [therapist] taught me ways to talk. Cause we used to be a yelling family. I'm not going to sit there and lie. We used to sit there and yell...cause it was the only way to get through to them... Now it's like, hey, you know what, what did I ask you to do? I expect it done within a certain amount of time. You have a certain amount of time to get it done. If not, you gotta stay in your room... That worked out a little bit” (1113).

This example demonstrates the negatively reinforcing cycle that was occurring prior to family therapy and the mothers' ability to employ principles of the SFT model to regain the authority necessary for functional patterns of interaction between parents and children.

Many participants believed that family therapy offered strategies for self-care that addressed their own stress and subsequently helped them to parent more effectively.

When discussing some of the self-care strategies offered, one participant stated, “[I put] myself in timeout, or to go take a hot bath, or just remove myself from the area...Cause if you don't get away, you're just gonna blow” (1113). When asked if the clinician ever asked about her feelings, another mother shared:

“Mmmhmm. That's why I would get in my car and just go. Even in the summertime, I would have my daughter-in-law com up and I would just go outside and get in the pool. I would stay in the pool for ½ an hour, 45 minutes, just to relax, then come back and deal with the situations....[The therapist's suggestions] calmed me down a lot” (1115).

Participants also described strategies that encouraged family cohesion and communication. One participant shared:

“...[the therapist] also mentioned for us to do family fun stuff because there was no fun left in our family anymore. We used to be the fun family...playing games...family game night...all that stopped. So, she did make little suggestions...homework...one thing was, I think the weather just started getting nice and she told us to open all the doors and windows and just let all the bad feelings out, so, like, little things like that kind of helped us...because she made us realize we needed to do something because we had all totally fallen apart from each other” (1114).

Mothers’ descriptions of learning parental coping strategies acknowledged their rapport with their family therapist. Mothers believed their therapists were teaching them necessarily parenting skills, but perceived a collaborative learning process where strategies were taught, applied at home, and then reviewed and refined during sessions. This collaborative relationship also contributed to families’ increased understanding of the presenting child’s behavioral health needs. These experiences suggest that mothers’ parenting needs were prioritized, as participants indicated that family therapy focused on enhancing their ability to manage their children and lowering parenting-related stress. While it is likely that these strategies improved mothers’ mental health symptomatology, it is not clear that family therapy provided mothers an opportunity to address their own mental health needs that were not related to their children’s behavioral challenges.

Insight. Participants expressed gaining insight to their child’s mental health needs as a result of family therapy. Mothers also indicated that siblings participating in family sessions gained insight to the presenting child’s needs. Participants believed that this greater understanding of the child’s behavioral health needs prevented all family members participating in treatment from reacting to the presenting child’s “unintentional” behaviors, ultimately decreasing dysfunctional interactions among family members. For example, one mother stated:

“...like if I’m out someplace and she’s acting like a butthead, she don’t mean to, like big crowds, she can’t do big crowds...there’s too many people, too much noise, too much everything going on, and it’s just... and she knows it now, where before she didn’t. Before, I didn’t. So that I would get aggravated, she would get upset, and it would just be a big blowup...But now at least...we can pick some triggers up” (1127).

Many participants described the insight gained by siblings as changing the patterns of interaction within the sibling subsystem. Mothers believed that siblings’ increased understanding of the presenting child’s behavioral health needs allowed them to stop reacting to and reinforcing symptomatic behaviors. One mother shared:

“...and also with the older kids, [they] were taught to realize the triggers of the youngest ones with the ADHA and last summer they didn’t realize that so when those kids was agitating them... the older ones would argue back and...now, they walk away...So rather than letting the little kids engage them, they’re able to see that, oh this is something to do with the ADHD, I’m not gonna start something, and then it’s not gonna escalate...So, now, they learned that so I’m hoping that this summer is going to be a pretty good one” (1111).

Some participants expressed that in addition to educating them about their child’s diagnosis and needs, family therapy addressed how their child’s behavioral health diagnosis may impact their own feelings. One mother explained:

“...so [the therapist] was asking me how I was feeling about it... made sure I wasn’t overwhelmed being that I’m a single parent with a five year old that has the diagnosis that normal five year olds don’t get....ODD is not common in kids, it’s more found in adults. So, she was asking me how I was feeling being that she has the diagnosis and it’s not common in kids to get it...” (1154).

As indicated by this mother’s experience, most mothers believed that family therapy acknowledged the impact of the presenting child’s behavioral health needs on the family dynamic.

Family Dynamic. Participants believed that family therapy had a positive effect on the overall family dynamic. Mothers' experiences indicate that they learned to recognize dysfunctional patterns of interaction and inappropriate interaction between family subsystems. Mothers discussed children trying to act on "an adult level" (1113) and the need to "take the reins and take control" (1150). For example, one mother stated:

"especially...because [presenting child] mothers [her brother]...ok, no offense, *I* am the mother...if I want [brother] to do something, I will tell him...and then she goes upstairs and starts crying...ok, wait a minute...just because you're not his mother doesn't mean you can't love him...but I will tell him what to do..." (1140).

Another mother's comments suggest an understanding of the need for gradual emancipation, explaining:

"I've learned to...I'm learning patience. I'm learning better communication with my daughter. Um, I'm not treating her like a child anymore. You know, I'm letting her make her own choices more and you know, guiding her but also you know, realizing she's going to be 18 in October" (1131).

Further participants believed family therapy made their family closer and improved communication. Participants described gaining greater appreciation and understanding of other family members' perspectives as a result of their therapy sessions.

When describing the impact that therapy had on her family, one mother stated:

"...we're all working on focusing on ourselves, ourselves as a family...we do everything together, just a fact...I'm not sure how to say this...we are always interested in each other's views and seeing each other's viewpoints and having a counselor that understands us and listens to everything everyone says...and granted, parenting is still a dictatorship...hint, hint...but we still value their opinions...and listening to value each other's opinions is an on-going process...so I think that's helped us a lot simply because she cares about what we think and she makes us better at expressing how we feel to each other" (1140).

Another participant concisely concurs, explaining, "...I think we're closer. I think we're a little bit more focused on each other's, um, things that we're all going through

separately, so that has helped, we've gotten a little closer" (1104). Participants' ability to understand the importance of boundaries to establish a functional organizational hierarchy in conjunction with the need to adapt with maturation, suggests a movement toward more functional patterns of interactions. These functional patterns are further demonstrated by participants' ability to encourage communication and understanding among family members. This also supports mothers' understanding of principles of the SFT model. Participants' ability and willingness to apply SFT principles at home suggests mothers were engaged in treatment and that it was acceptable to them.

Gateway to Individual Treatment. Five of the sixteen participants discussed their decision to initiate individual treatment as a result of attending family therapy. Some mothers believed family therapy helped them with parenting, but felt individual therapy would more directly address their own needs. One participant explained:

Yeah, I started going to therapy myself too here. [Individual therapy] helped me deal with stuff that I was dealing with personally on top of the parenting stuff so it took a bit of the edge off of everything that was going on, so it was a lot better. Yeah" (1104).

Participants' experiences with family therapy suggest that the treatment helped them acknowledge their own mental health needs while establishing a comfort level with treatment. When describing how family therapy impacted her, one mother stated:

"It probably brought [my depressive symptoms] to the surface more and upset me more because I thought I was OK and I was dealing with this, but that probably was the turning point for me because of somebody to say to you...on the outside looking at you...I'm worried about you..." (1114).

Some mothers reported a desire for individual treatment but experienced financial barriers preventing them from getting services. Participants explained that while family

therapy was covered under their children's insurance, they either did not have insurance or did not have a plan that provided adequate mental health coverage. One mother states:

“Oh yeah, [individual treatment] would be majorly helpful. It's just, right now, I don't have medical, that's coming out of pocket. I'm the only one working right now, my husband's working jobs that really aren't that great, you can't afford to do stuff, that's where I'm at” (1127).

Participants' experiences suggest that even if they didn't perceive family therapy as an intervention to address their own personal needs, the treatment addressed their feelings and likely encouraged them to seek individual treatment. Additionally, mothers' positive experiences with family therapy, as exemplified by their perceptions of their children's improvement and their own ability to more effectively manage their children, may have led them to give the mental health service system another chance for themselves. To this end, family therapy may offer an important solution to engaging a particularly hard to reach population. However, mothers' attempts to secure individual treatment also present an important access issue. Mothers reported that even if they desired individual therapy, they could not afford the cost of sessions. Family therapy may be an innovative, cost effective option available to low-income mothers or mothers who are uninsured or underinsured. However, more work needs to be done in order to understand why mothers don't see family therapy as an avenue for addressing mental health needs that aren't associated with parenting. It is important to consider the role of implementation, as it may be that clinicians influenced mothers' perceptions by not focusing on their mental health needs outside of parenting.

Lack of Fathers' Involvement. Participants also expressed frustration over fathers' lack of involvement in family therapy. Mothers believe the lack of involvement in family therapy prevents fathers from understanding child's needs, contributing to continued

relationship problems. When describing the relationship between family members, one mother states:

“...[presenting child] and my husband are having a lot of friction and [my husband] should be going to more of [child’s] counseling appointments too but I can’t do nothing about that...I’ve tried but he works third shift and wants to sleep so I understand...” (1104).

Participants also indicate that the lack of involvement impacts the parental relationship as well. Mothers discuss the difficulty of establishing a parental coalition when one parent does not fully engage. One participant described herself as the “main controller” since her husband works full-time. Another participant exasperatedly explained:

“My husband makes it into something that it’s not...Um, I deal with this 24/7 from the time I get up till the time she comes home till the time she goes to bed. Um, it’s me with all the kids. So, uh, it is very difficult when you have somebody, like when he was on the road for the last year, comes home on the weekends and looks at me like I’m a moron...and dealing with the craziness, um, no, I don’t think [he] gets the full one-on-one aspect because he sits with that laptop on his lap and just doesn’t acknowledge anything that’s going on” (1127).

The participants above represent mothers discouraged by the lack of support of fathers who live in the home but don’t actively contribute to addressing their children’s needs through therapy. However, some other participants described fathers who weren’t involved because they weren’t in the home at all and had no relationship with their children. These participants expressed concern that their children’s behavior in some may reflect the absence of their fathers and indicated that their own stress level increased after the child’s father left.

It is likely that the intervention’s focus on mothers and children may have unintentionally contributed to a lack of fathers’ involvement. However, it also may be

that mothers' participation in family therapy and exposure to the Structural Family Therapy model made them more aware of the consistent parental support necessary to restore their families' organizational hierarchy. For example, if mothers who were married or living with a partner were trying to reestablish boundaries of the parental subsystem and regain control of the family hierarchy, it may be that fathers who weren't involved in treatment continued to engage in interactions that encouraged cross-generational alliances and undermined mothers' attempt to move toward more functional patterns of transaction and ultimately achieve family functioning. Mothers' perceptions suggest the importance of including all family members in treatment, which is consistent with the underlying systemic orientation of SFT.

Implementation of Family Therapy. The final core category presented deals with the implementation of family therapy. Participants' experiences with family therapy gleaned insight to aspects of implementation that impacted their care and identified challenges related to implementing empirically supported interventions within routine treatment settings. Participants' use of language reflected core concepts of the Structural Family Therapy model, indicating that therapists adhered to at least a basic level of model fidelity. However, participants' perceived family therapy as being for their children, suggesting disconnect between the adapted model's focus on maternal engagement and the care provided. Additionally, mothers identified inconsistency of treatment as a major concern and often attributed the inconsistency to characteristics common in routine practice settings, such as high caseloads and too few clinicians trained in family therapy. While mothers continued to express belief in the family therapy model, they perceived the inconsistency as negatively affecting their treatment experience. Finally, participants

believed that their children's severity also impacted their experience with family therapy. Some mothers described attending a few sessions of family therapy and then being transferred or referred to more intensive or restrictive treatment settings. Mothers continued to express support for the family model and service delivery, reiterating that it was their child's level of impairment that prevented family therapy from "working".

Again, due to the non-leading structure and engagement focus of the semi-structured interviews, there were no questions specifically addressing implementation of the family therapy. Mothers' insight to implementation issues was generated from responses throughout the interviews.

Language. Participants' language reflected core aspects of the Structural Family Therapy model, which was an indication of model fidelity. Mothers consistently used language describing core aspects of the basic SFT model, often focused on restoring the organizational hierarchy of the family, and expressing the collaborative relationship that developed between the family and their therapist.

Through sharing their experiences with treatment, participants revealed an understanding of the organizational hierarchy, which SFT asserts is necessary to maintain family functioning. Mothers' experiences most commonly focused on restoring boundaries of the parental subsystem. Mothers' descriptions of family dynamics indicated their recognition of presenting children who were pushing through the boundaries of the parental subsystem and the importance of restoring that boundary as well as the organizational hierarchy. One mother stated, "...cause [presenting child] thinks he's the head of all of us... We needed to find someone to take him back down to a kid level rather than an adult level" (1113). However, participants' shared experiences

also revealed an understanding of a gradual emancipation, the importance of the sibling subsystem and parental coalitions.

Participants' language also demonstrated the rapport that families had with their therapists, specifically acknowledging that the therapist had entered the family subsystem. Mothers often spoke in the collective when discussing strategies or decisions made in therapy sessions, referring to the family and the therapist as one unit. When discussing her child's progress since starting therapy, one participant stated: "Things are turning around...Now I still have a problem with the stealing, but she only steals from me. Only me, and we don't understand why. We can't get to the butt of that..." (1115). This statement indicates that the therapist is part of the system and that the mother and therapist are working together to understand the child. One participant described being "on the same page" (1140) with the therapist and while another explained that their family and the therapist "all just clicked very well together" (1114). Participants also believed they had a more important role in therapy due to the collaborative relationship established by the therapist. For example, one mother shared: "...and I felt like I knew what was going on because I was in the circle so that really helped me a lot" (1104). However, despite this rapport, mothers still believed family therapy was for their children.

Child v. Family Therapy. Many participants perceived family therapy as being for their children and did not see it as an intervention meant to address their own needs. This suggests an implementation concern, as one of the adaptations emphasized maternal engagement and intended to prepare mothers for treatment by explaining family therapy as a way to concurrently address their children's needs with their own needs.

Most participants believed family therapy was as an intervention to treat their children. When describing the therapy, one mothers stated, “Well, [presenting child]’s the main person. If [therapist] call for one [family session], yeah, but if not, we let him...” (1113). Even when therapists specifically asked about their feelings and needs, mothers still perceived family therapy as child-centered. For example, one participant shared:

“[Therapist}, um, she asked how I felt, what I wanted to see done. She did. She would say things like, ‘You know your mom’s anxiety’s high’...I was glad. You know? I was glad that she brought it up and we could talk about it...[but] she was more [presenting child’s] therapist, so...” (1137).

Mothers’ perceptions of treatment suggest that the purpose and underlying rationale of family therapy were not discussed. While mothers readily acknowledged the link between their children’s behavioral challenges and their own needs as a reason for seeking family therapy, it appears as if the treatment’s focus on restructuring underlying patterns of transaction that maintain presenting problems was not communicated. It is likely that the family therapist was never viewed as a provider for all family members, but as a therapist for the identified patient. If the family continued to focus on the identified patient as having individual deficits that required family therapy and not as one member of the family whose challenges involved the interaction of all family members, it is likely that the identified child’s needs would not be addressed.

However, one mother described experiencing a change in her perceptions of family therapy over the course of treatment, explaining:

“Um, at first I kind of was like, um, not offended, but kind of like, wow, we’re here for [presenting child], not me, you know, um, and then I’m thinking I can’t afford it anyway so it doesn’t matter but at first I kind of almost was offended but then sitting back thinking about it, oh my god, this is just not one, it’s both of us, so...” (1131).

This mother's experience indicates resistance to being an identified patient as well the realization that her child's problems were intertwined with her own needs. It is likely that this mother was comfortable with family therapy because she viewed it, or it was sold to her, as an intervention to treat her child's behavior challenges and she didn't anticipate the therapist's focus on her own mental health needs. However, it may be that the therapist's dual focus allowed this mother to change her perception of treatment and no longer view the child's presenting needs as the problem. This suggests that even if purpose of family therapy was not explicitly described to participants, therapists may have incorporated elements of the model that focused on identifying and changing underlying patterns of transaction between family members.

Inconsistency. Many participants identified the inconsistency of family therapy as their primary concern and believed that the inconsistency negatively impacted their treatment experience. Most mothers believed characteristics of the community mental health system contributed to the inconsistency; though some attributed their chaotic lives to the irregularity of treatment sessions. Mothers endorsed the family therapy model, believing that the treatment would have been successful had their families received more care.

When sharing her family's experiences with treatment, one participant stated:

“Um, our services weren't consistent enough, which I shared with our therapist and she agreed, but I guess they're just so overwhelmed and understaffed that we just were not able to be consistent. I really wanted to be able to see her once a week, *at least*. And there would be weeks that would go by and we didn't even see her. So that was a big issue and I think played a big part on things not coming to where I wanted them to be...One time it would be every two weeks and then it would stretch out to four or five weeks and I thought, this isn't gonna work, it's not. And it had nothing to do with our therapist at all. She just didn't have enough hours in her book to see all the families...Family Services is basically

the only place we can go [because of our insurance]. And, they're obviously overloaded..." (1114).

Another mother expressed her frustration with the lack of evening appointments, and how the clinic's hours of operation made it difficult to make family therapy sessions while working full time, explaining:

"Family Services, I don't have that option. You don't get those options. You know with [child] it's a pain in the ass getting her to counseling cause [therapist's] last appointment is 4:30, well, I don't get off work till 4:30, she doesn't drive, and even if she did, she doesn't have a car. I have to figure out somebody to take her to counseling and then I pick her up, and then the days that I want to try to get in there, I have to leave work early so that's a pain in the butt, but, you know, that's the only beef I have about it now, you know, so if it's, as long as I can get her there, I'm good, so..." (1131).

Still, some other participants described hectic lifestyles that prevented them from regularly attending family therapy sessions. As one mother described:

"I didn't always live here...and I was bouncing around...So there were a lot of appointments that I had to cancel. And I couldn't attend or make up, um, I'm not saying, like, if I had to refer anybody, I would definitely refer them, definitely, I know, I know like they always tried to do the next step...period" (1132).

In general, the inconsistency of family therapy calls into question the feasibility and sustainability of implementing model based care within the community mental health setting. It's not realistic to expect families to get the duration or intensity of sessions provided to participants in laboratory or university settings; however, when families seeking community treatment go for weeks without a therapy session, it inhibits their ability to improve. For example, on average, families receiving Structural Family Therapy went four weeks between treatment sessions. It is likely that with so much time between sessions, families could easily revert back their old, comfortable, dysfunctional patterns of transaction. Additionally, the inconsistency also inhibits clinicians' ability to

treat families. A central component of SFT involved the joining process, where the therapist essentially enters the family system. If clinicians do not see families on a regular basis, it is likely that they will not be able to establish the trust and rapport necessary to join the family system. Further, it may be difficult for clinicians in the community mental health setting who manage large caseloads to remember what was done at the last family session. As a result, it may take longer for clinicians to identify dysfunctional patterns or even appropriately diagnose more severe behavioral health needs. Family therapy is difficult in the first place as clinicians are simultaneously addressing the needs of multiple family members and assessing the family's patterns of interaction. When clinicians see family cases so infrequently, they may not develop the confidence or expertise necessary to effectively administer family treatment, even one like SFT that is based on basic principles and designed to be accessible to paraprofessionals. This is likely to be exacerbated for clinicians who did not have a background in family treatment prior to training.

It's Not You, It's My Child. Participants indicated that their children's severe impairment impacted their decision to seek family therapy, yet many participants also believe it ultimately affected their experiences in treatment. Many participants describe attending a small number of family therapy sessions before their children were referred or transferred to more intensive or restrictive treatment settings. One mother explained:

"They tried outpatient service with her and that didn't work. Then they tried in-home like the therapy come in the home with the family-based type thing and that didn't work either, and then we took her to a respite for 28 days and she got worse and now she's in RTF. She was in Western Psych, you know, and at first we thought it was us but then um...wherever she goes, there she is. So, it doesn't have anything to do with who's caring for her. I don't think it's any of the services. It's her" (1102).

Participants expressed belief in the family therapy model and believed their children's complicated behavioral health needs rather than the treatment model itself prevented success in the outpatient setting. For example, a mother stated:

“...I can't say that anything wasn't helpful because the things that didn't help are supposed to...it's like they've done everything they could with [child] and we're still, even though it's beyond *them* now, some of the stuff he's going through, they're still working with me, I'm getting to the next step, it's just a process...We're actually working on getting him in a school now that's counseling and like a private school kind of but with round-the-clock counseling so he can stay on his work.” (1104).

In fact, some mothers even suggested that they would like to continue outpatient family therapy after their children complete the more restrictive or intensive treatment. One mother stated:

“We had a break in services because we went from [outpatient family therapist] to street...no, not street-based, I can't think...it was family but there's two people that come...I can't remember what it was called but we went from [outpatient family therapist] and then back to seeing a doctor then they thought that we...meet inside the home...Now since that stopped, I'd rather get back to seeing [outpatient family therapist] because I'll tell you what, there's no other person down there that I'd rather have my son see than her. She helped the family tremendously” (1113).

These findings suggest that mothers view the mental health system as an authority and trust the actors within the system to make the right decisions to address their children's behavioral health needs. It also appears that some mothers have had multiple experiences with their children “failing” and being moved to a new treatment modality. While mothers believe their children's severity prevented their success, it may be that aspects of the system were “failing.” For example, in this case, it may be that clinicians lacked the appropriate skill levels to accurately identify the children's treatment needs during the

initial assessment. As many of these children had severe impairment, it may be that outpatient treatment was simply not appropriate and that some children should have been referred directly to a more restrictive or intensive setting. Additionally, the inconsistency of treatment sessions likely made it difficult for therapists to account for children's treatment needs in a timely manner. On the other hand, agency administrators conceptualized family therapy as an important step-up to and step-down from family-based in-home services and partial hospitalization programs. From this standpoint, family therapy met an agency-identified need. As the majority of children presenting for family therapy were severely impaired, it is likely that family therapy offered a less restrictive, more cost-effective option. However, since children's self-rated mental health symptomatology did not improve with time spent in treatment, the use of family therapy in this setting requires further examination.

4.2.2 Treatment Satisfaction Results

Descriptive analyses of treatment satisfaction measures suggest high levels of satisfaction with family therapy. Mothers' average scores on the 8-item Consumer Satisfaction Questionnaire were 28.28 at 3 months and 27.91 at six months. As the scale ranges from 0 to 32, with higher scores associated with greater satisfaction, these scores suggest SFT was an acceptable treatment option for mothers. Similarly high scores were found when analyzing the Charleston Psychiatric Outpatient Satisfaction Scale. On the 15-item scale, ranging from 0 to 65, where high scores indicate greater satisfaction, mothers' average scores reached 54.84 at three months and 51.41 at six months. Again these scores indicate a high level of satisfaction; though participants reported slightly greater satisfaction at three months when compared to six months. This may be due to the

fact that families received less treatment between three and six months; however these differences were quite small and, in general, suggest the acceptability of family therapy for mothers who are initiating care for their presenting child within routine practice settings.

It may be that dissatisfied families discontinued treatment and dropped out of the study. However with the low dosage of treatment, on average less than one session per month, it is likely that mothers' were still developing their assessment of the treatment during the study period. To this end, treatment satisfaction is relevant and has utility in assessing the acceptability of family therapy.

4.2.3 Summary of Qualitative Results

Acceptability. Qualitative data suggest that Structural Family Therapy (SFT) was an acceptable intervention for mothers initiating services for their children in a semi-rural community mental health setting. Mothers' reasons for choosing family therapy indicate that they viewed a family approach as having added value over individual child treatment. In addition to their children's severe behavioral health needs, mothers seeking treatment were experiencing high levels of stress and chaos in their own lives and most had a previous mental health diagnosis. Mothers believed their own stress resulted from their children's behavioral challenges and felt as if they could no longer manage their children without help. It is likely the perceived interrelatedness of their own and their child's problems, combined with their desire to enhance their parental capabilities, influenced mothers' decision to seek family therapy.

Additionally, participants perceived family therapy as effectively addressing their main reasons for seeking treatment: their children's severe behavioral health needs and

their own inability to effectively manage those needs. Mothers believed that Structural Family Therapy positively impacted their child's behavioral health; their own ability to cope with their own needs while managing their child's illness; as well as the overall family dynamic. These results suggest that SFT provided an acceptable intervention for mothers in community settings.

However, mothers clearly viewed family therapy as a way to meet their parenting needs, not necessarily their own mental health needs. It is not clear if this is due to mothers' resistance to being an identified patient or an implementation issue, where clinicians did not address mothers' mental health needs separate from parenting. Further, findings indicate that some mothers acknowledged their own mental health needs as a result of family therapy and sought individual treatment. It is likely that attending family therapy sessions brought mothers' feelings to the surface and made them more comfortable with mental health services, leading them to give treatment for their own needs another chance.

Further, mothers perceived other family members outside of the mother/child dyad as integral to the treatment process. First of all, mothers believed that siblings gained insight to the presenting children's behavioral challenges through family therapy and that the insight ultimately led to increased family functioning. For example, siblings would refrain from engaging the presenting children in conflict because they were able to identify behaviors that were symptoms of behavioral health needs. Second, mothers perceived a lack of fathers' involvement that negatively impacted their experiences with family therapy. Mothers' experiences suggest that fathers did not understand their children's behavioral challenges and that they did not support them in reestablishing the

organizational hierarchy or in managing their children's needs. The study's focus on mothers and children may have unintentionally deterred fathers from participating; though, the findings suggest that future work should examine outcomes of all family members.

Descriptive analyses of treatment satisfaction found mothers in the current study were highly satisfied with family therapy throughout the duration of the study period, another indication of its acceptability.

Sustainability. Mothers' perceptions of family therapy also gleaned insight to issues of implementation, which affected their treatment experience. Qualitative data suggest a basic level of model fidelity as mothers' language endorsed core principles of the SFT model and their shared experiences demonstrated their ability to apply these principles at home. Therefore it is likely that a basic level of model fidelity was achieved and there may have been some routinization of the intervention.

However, some significant implementation challenges emerged that question the sustainability of SFT within the community mental health setting, including inconsistent treatment dosage, mothers' view of SFT as child treatment, and the referral of children receiving SFT to more restrictive or intensive settings. Mothers believed that the inconsistency of family therapy, in conjunction with their children's severe challenges, negatively impacted their experiences with family therapy. Families receiving SFT on average had one treatment session per month. Mothers most commonly attributed the inconsistency to high caseloads and not enough qualified family therapists. Mothers believed the SFT model was good, but felt it wouldn't work unless they had more frequent session. It may be that the inconsistency prevented therapists from effectively

engaging in key aspects of the model, such as joining, that require establishing a level of trust and rapport with the family. Further, it is likely that when families have so much time between sessions, they will revert back to familiar, yet dysfunctional, patterns of transaction. It may be difficult to address this concern without structural changes to the community mental health system.

Additionally, mothers essentially viewed family therapy as child therapy. Qualitative data suggest that mothers did not see themselves as an identified patient, even though their own feelings and parenting needs were addressed. This indicates that mothers did not understand the purpose of SFT, in that children's behavioral health needs resulted from dysfunctional family structures. If mothers continued to view their children as the only identified patients, it may inhibit their children's ability to improve. These results may also suggest an implementation problem. A key model adaptation for the implementation of SFT within the community mental health setting centered around maternal engagement and introducing SFT as an intervention to address mothers' needs as well as their children's; however, it may be that this was not communicated to mothers. Further, family therapy is difficult and its effective implementation may have been beyond some of the therapists' skill level.

Finally, while mothers believed in the SFT model, some indicated that their children were referred to more intensive or restrictive settings, such as in-home family based services or partial hospitalization programs. Mothers attributed this to their children's severe behavioral health needs. This may be the case. However, it also raises an implementation concern regarding diagnosis at the initial assessment. Therapists determined the appropriate level of care for the presenting child's during the initial

assessment. If outpatient therapy was recommended, families were given the option of SFT. It may be that clinicians underestimated some of the children's severity or did not have the skills to adequately diagnose the children. Further, as previously noted, the inconsistency of sessions may have prevented the therapists from recognizing the children's severity in the early sessions.

Qualitative findings suggest that Structural Family Therapy shows promise for addressing mothers' and children's mental health needs in the community mental health setting; though, future work must focus more on model implementation. Mothers' perceived the SFT as an acceptable treatment option to meet their own needs and their children's needs and found family therapy to positively impact their family dynamic. Mothers' experiences indicated they were engaged in treatment, collaborated with their therapists, and applied core aspects of the SFT model at home. Though mothers believed SFT was acceptable to treat their parenting needs not their personal mental health needs, attending family therapy likely provided encouragement to seek individual treatment.

SFT could be a potentially effective, acceptable intervention to employ within the community mental health setting, but qualitative results indicate that critical implementation concerns must be explored and addressed. Mothers appeared to be attracted to the value of family approach, yet continued to identify SFT as child treatment. This suggests that the rationale and goals of the treatment were not communicated to the family, potentially inhibiting improvement. In addition, children entered treatment with severe behavioral challenges and perhaps needed care above and beyond what can be provided through outpatient therapy. Clinicians may have underestimated these children's needs. Most importantly, families simply did not receive

consistent treatment. In order to effectively implement SFT, or any model based care, within the community mental health setting strategies to address high caseloads, too few clinicians, and restrictive hours of operation must be considered.

5.0 DISCUSSION

Although many studies have examined the efficacy of family therapy for child behavioral health outcomes in laboratory settings, most often controlled trials (Carr, 2000a; Shadish et al., 1993; Shadish & Baldwin, 2003), few studies have examined the effect of family therapy in routine practice settings. To date, even fewer studies of family treatment have addressed parental outcomes (Liddle et al., 2002; Schuhmann et al., 1998), and only one study has specifically examined the intervention's impact on maternal mental health symptomatology (Barkley et al., 1992). This research presents data on the effectiveness, acceptability, and sustainability of Structural Family Therapy for children presenting for treatment in a semi-rural community mental health setting and their mothers. In this study, the hypotheses were partially supported by the results. Mothers' mental health symptomatology and perceptions of their children's impairment statistically significantly improved with time spent in family treatment, while there were no statistically significant differences on children's self-reported mental health symptomatology. Overall there were no statistically significant differences on maternal functioning with time spent in family therapy; though results suggest functioning may have significantly improved for those mothers who were symptomatic at baseline. The following chapter discusses the results of this study in greater detail, interpretively integrating the quantitative and qualitative results in order to provide an in-depth

presentation of study findings. Next, the limitations of the study are discussed, followed by a presentation of the implications of the study's findings. Implications are identified for both research and practice. This chapter concludes with a synthesis of the information presented in the results and discussion chapters to offer a cohesive understanding of family therapy's effectiveness for children and mothers and its acceptability and sustainable for families receiving care in the community mental health setting.

Treatment Effectiveness. Results of this study provide some support for the treatment effectiveness of family therapy for mothers and their presenting children within a semi-rural community mental health setting. The first hypothesis that mothers' mental health symptomatology and functioning would improve over time spent in family therapy was partially supported. Mothers' depressive symptomatology and anxiety significant improved over time spent in family therapy. This held true for a subsample of mothers who were symptomatic at baseline, with much larger effect sizes. Overall, the results suggest mothers' functioning did not statistically significantly improve over time, yet steadily declined during the six-month study period. For mothers who were symptomatic at baseline, findings indicate that functioning may have significantly improved over time spent in family therapy, and confirmed a steady decline over time. This study supports previous work demonstrating the link between maternal and child's mental health needs, as the majority of mothers participating in this study were experiencing mental health symptomatology when initiating family therapy for their children. Findings from the current study suggest the potential utility of family interventions for addressing mothers' mental health symptomatology within routine treatment settings.

The second hypothesis that children's mental health symptomatology would improve over time was partially supported as well. Children's depressive symptomatology did not change over time spent in family therapy, nor did children's ratings of their impairment. However, mother's ratings of their children's impairment significantly improved over time spent in family therapy. It should be noted, that despite significant improvement over time in family therapy, mothers' ratings suggested that, on average, children remained impaired at the six-month time point. It is likely that the low dosage of family therapy – on average families in this study received 5.61 sessions over six months – was not enough to adequately address children's severe impairment. While the average dosage families received in this study (5.60 sessions), is consistent with the average dosage received by consumers in routine treatment settings (4.3 sessions), it is drastically different from the high number of sessions typically required in efficacy trials (13-17 sessions) (Hansen et al., 2002). It is also possible that children seeking family therapy within the community mental health setting experienced greater impairment or different types of impairment than children referred for efficacy trials. These findings suggest that issues of implementation and sustainability need to be further examined when translating family therapy to address children's behavioral health needs in routine mental health settings.

Qualitative semi-structured interviews with mothers receiving family therapy provided information that contributes to a more comprehensive understanding of these results. Mothers indicated that they chose family therapy because they felt overwhelmed and believed their children's behavior problems exceeded their capabilities as parents. Mothers believed family therapy provided them with coping strategies and insight to their

children's behavioral health needs. Developing these skills subsequently allowed mothers to more effectively deal with their children and lower their own stress levels, which likely translated to the observed improvement in mental health symptomatology and ratings of their child's impairment. Even though families, on average, did not receive a lot of family therapy, mothers' experiences indicate that they learned parental coping strategies and applied them at home. Further, mothers' expressed an understanding of SFT principles, such as the organizational hierarchy needed to establish functional patterns of interaction. For example, some participants discussed re-establishing the boundaries of the parental subsystem and taking back parental authority. Restoring the family's organizational hierarchy also could have contributed to mothers' improved mental health symptomatology.

The overall lack of significant improvement in maternal functioning connects to mothers' descriptions of their chaotic lives, filled with ups and down. Some mothers described their lives as "rollercoasters" and perceived their existence a series of ups and downs that never reached equilibrium. This constant flux may have in fact led mothers to develop resiliency, as they have had no choice but to learn to function despite the chaos around them. It is also likely that the chaotic lifestyle was normalized for these mothers. While the Sheehan Disability Scale, used to measure maternal functioning, ranges from zero to 30 with higher scores indicating more life disruption, mothers' average score at baseline was 11.87. While the scale does not provide cut-points, this researcher believes that mothers' baseline scores further support the assertion that they are resilient to the complex, multiple problems they experience. Mothers who were symptomatic at baseline reported greater levels of functional impairment as well and results suggest that these

mothers may have experienced a significant improvement in functioning with time spent in family therapy. It may be that mothers dealing with their children's severe behavioral health needs in conjunction with their own mental health symptomatology led to a level of chaos that exceeded what was normal for these families. Further, mothers perceived family therapy as addressing their children's needs, their own parenting needs, as well as their family dynamic, all of which may have contributed to an improvement in maternal functioning.

While mothers seemed to have benefitted from family therapy despite the low dosage received, the lack of change in children's self-reported mental health symptomatology was likely impacted by the low dosage combined with their high levels of impairment. Mothers' described their children as having significant behavioral health problems (i.e. suicidal ideation; conduct problems at school resulting in suspension/expulsion) that ultimately required more restrictive, intensive programs or services, such as family-based in-home services or a partial hospitalization program. While most mothers expressed satisfaction with family therapy, they also believed it was too inconsistent, in part due to outpatient community mental health setting limitations of high caseloads divided among too few clinicians. It may be that the inconsistency of family therapy combined with the children's severity prevented the children's mental health needs from being adequately addressed. Mothers' ratings of children did improve and qualitative data indicated that mothers' perceived improvement in their children as a result of family therapy. However, even at six months, mothers' ratings of their children still suggested impairment. Further, mothers' described developing parental coping strategies and insight to their children's needs that likely influenced their view of their

children's impairment. For example, even if children's behavioral health needs weren't adequately addressed, mothers and other siblings gained insight and were able to stop reacting to behaviors, therefore stopping the negatively reinforcing cycle. This is of concern as mothers' perceptions of child improvement may lead them to discontinue treatment before their children's needs have been addressed.

Acceptability of Family Therapy. Results of the thematic analysis of the qualitative interviews and the descriptive analysis of treatment satisfaction suggest SFT was an acceptable intervention for mothers whose children present for care within a community mental health setting. Mothers believed family therapy resulted in a number of positive outcomes, including their own decreased stress levels and ability to more effectively manage their children, their children's improvement as well as an improved family dynamic, and a calmer home environment. Mothers explicitly endorsed standardized elements of the SFT model, described using techniques taught by their family therapist, and viewed themselves as part of a collaborative relationship with their therapist. These positive outcomes suggest that family therapy addressed mothers' reasons for seeking treatment, specifically their children's severity and their inability to effectively manage their children. Mothers perceived family therapy as successfully and simultaneously addressing their own parenting needs and their child's needs. Even when family therapy did not result in the desired outcome, mothers still expressed strong support for the model.

While mothers felt SFT was an acceptable treatment model, there are two important caveats that emerged from the study findings and must be considered. Mothers reported that family therapy met their immediate needs, as they perceived SFT as

positively impacted their children's behavioral health needs. However, children's self-report measures indicate that they did not experience improvement with time spent in family therapy. It is likely that mothers' own improvements influenced their view of their children. This assertion is supported by previous research demonstrating that parent ratings can be influenced by their own moods (Achenbach, 1995; Bird et al., 1992). In this case, it is likely that as mothers' gained parental coping strategies and their own mental health symptomatology decreased, may have caused them to inaccurately perceive a positive change in their children. Mothers' experiences indicate they were restoring an organizational hierarchy, which likely improved family functioning. Again, establishing more order in the home and being able to more effectively manage their children may have cause mothers to confuse an improvement in family functioning as an improvement in their children's behavioral health needs. In total, mothers' own improvement not only influenced their perceptions of their children, but also likely influenced their views of SFT as an acceptable intervention. Further, this study did not elicit children's perceptions of the family therapy. It may be that children did not find SFT acceptable and therefore didn't engage in treatment.

The second important caveat concerns mothers' perceptions of SFT to treat their own needs. Mothers clearly found family therapy acceptable for treating their parenting needs. Many mothers described central elements of the SFT model that allowed them to regain parental authority, increase healthy, appropriate communication with their children, and stop negatively reinforcing patterns of interaction. It is very likely that these strategies and mothers' ability to manage their children led to an increase in their mental health symptomatology. However, mothers clearly delineated SFT as being acceptable

for treating their parenting needs but not necessarily successful for addressing their personal mental health needs. Many mothers shared their own mental health history and indicated that they had unmet mental health needs. These mothers did not view family therapy as an appropriate place to address their needs outside of parenting. While mothers' experiences suggest that family therapy encouraged them to seek individual treatment, they ultimately viewed SFT as child therapy. Family therapy is equipped to simultaneously address concurrent needs of multiple family members. Each family member's individual needs contribute to the dysfunctional patterns of interaction and prevent the family's ability to adapt and move toward healthy structures. It may be that this was not communicated to mothers. It also is likely that mothers resisted being an identified patient. Previous research reveals that while mothers acknowledge the interconnection between their own and their children's mental health needs, they believe they will improve if their children's needs are met (Anderson et al., 2006). In this case, it may be that mothers viewed their parenting needs as a part of their children's needs and continued to believe that their own mental health needs would improve as their children got better. In fact, it is likely the model's focus on mothers in relation to their children and the stress of caregiving, appealed to mothers as it allowed them to receive care without being labeled or pathologized. The separation mothers created between their parenting needs and mental health needs indicates that mothers may not find family therapy acceptable for treating their personal mental health needs, though future work should explore this observation in conjunction with its relationship to implementation.

Despite these concerns, mothers' appear to value the family approach. As previously mentioned, mothers had an awareness that their own needs were related to

their children's needs. Since mothers chose to initiate SFT, it is likely that they viewed family therapy being value-added when compared to individual child treatment or individual treatment for themselves. Mothers perceived their relationship with the family therapist as collaborative and shared specific examples where they applied a strategy or technique learned in therapy at home. While individual therapy for mothers may address parenting issues in a general sense, it is likely that family therapy provided an opportunity for mothers to obtain strategies specific to the family dynamic observed by the therapist. This likely resulted in more effective child management and subsequent improvement in maternal mental health symptomatology. Ultimately, family therapy emerged as a potentially acceptable way to engage a hard to reach population of mothers that requires further examination.

Sustainability of Family Therapy. Mothers' insight to implementation issues addressed the sustainability of family therapy within this semi-rural community mental health setting. Mothers' experiences suggest a basic level of model fidelity, and perhaps even some routinization, but identify implementation challenges critical to the intervention's sustainability. These challenges include: 1) inconsistency of treatment; 2) an identification of family therapy as child treatment and 3) children's referral from family therapy to more intensive or restrictive settings.

The low dosage of treatment provided over the study period, on average one family therapy session per month, was inadequate and represents a substantial barrier to sustainability. Mothers' believed that the inconsistency of therapy sessions negatively impacted their treatment experience and some mothers felt it prevented their families' ability to improve. The inconsistency of SFT affects its sustainability as it discourages

consumer engagement, inhibits clinicians' ability to effectively administer core aspects of the model, and provides an opportunity for families to revert back to familiar, yet dysfunctional, patterns of transaction. When families receive such sporadic care, they do not develop a treatment routine. This can make it difficult to remember appointments while juggling the multiple demands of family life. Further, when therapists can only see families once a month, it is likely to make families' feel as if their problems aren't that important. Both of these factors impact engagement. Given the inconsistency of treatment, it is impressive that the majority of families, approximately 75%, received SFT throughout the six-month study period. This likely speaks to the intervention's acceptability; though it may also indicate that these families were desperate for services and willing to take what they could get. Additionally, it is likely that infrequent sessions impacted clinicians' ability to establish the trust and rapport necessary to join the family system, which is a critical component of the SFT model. If therapists do not join the family system, they are unable to diagnose dysfunctional patterns of transaction and move the family toward healthier structures. This may have impacted the intervention's overall impact. Finally, it may be that the length of time between sessions prevented the support and guidance necessary to change dysfunctional patterns of transaction that were likely a normal part of the family's life for some time. Without reinforcement from the therapist and the ability to enact and work through structural changes during treatment, it is likely that families reverted to their familiar, dysfunctional patterns of interaction between sessions. The inconsistency of treatment session likely impacted clinicians' ability to effectively administer the SFT model and may have unintentionally discouraged

families' treatment adherence and attendance, representing a threat to the sustainability of SFT within the community mental health setting.

Second, mothers viewed SFT as child therapy. Not only is this view a direct departure from the intervention's underlying conceptualization of presenting problems stemming from the family's organizational structure and patterns for transactions, it also goes against the goals of model adaptations specifically designed to encourage maternal engagement and communicate SFT's ability to concurrently address mothers' and children's mental health needs. This departure may indicate an implementation problem, as mothers may not have been properly informed about the purpose of SFT. It is also likely that mothers resisted the label of identified patient and were more comfortable viewing themselves as involved in their child's treatment. This may have allowed mothers to lessen the stigma associated with mental health services. Regardless, mothers' perceptions of SFT as child treatment likely contributed to their children's lack of improvement over time spent in family therapy. Children presented for treatment and were initially the identified patients. However, family therapy contends the child's symptoms are related to the family system and structure. If mothers continue to view their children as the identified patient, it may be that the focus is placed on the children's individual deficits and not enough attention is placed on the families' role in perpetuating the children's symptomatology. If the rationale of family therapy is not understood, it is likely to prevent children's improvement and therefore compromise the sustainability of the intervention.

Finally, some mothers reported that their children were referred from SFT to more restrictive or intensive treatment settings. While mothers felt this was due to their

children's severity, it is likely that system level factors contributed to this pattern as well. The majority of children receiving SFT were severely impaired at baseline, which may accurately reflect the children presenting for treatment in community mental health settings. However, it also may be that outpatient therapy was not appropriate for some these children and that clinicians did not accurately assess their severity upon initial assessment. This study did not set exclusion criteria based on diagnosis. If clinicians' felt outpatient therapy was appropriate, families were eligible to receive SFT. As a result, clinicians who were less experienced may have underestimated children's needs or failed to detect an organic problem. The inconsistency of family sessions may have made it more difficult for clinicians to recognize children's severity level in a timely manner. However, agency administrators viewed SFT as an important, potentially cost-effective step-up to and step-down from more intensive or restrictive settings. In that case, the intervention may have addressed an agency need; however, considering that children's mental health symptomatology did not improve over time, it is likely that more attention should have been placed on identifying children whose needs were appropriate for family therapy. If children do not improve with time spent in SFT and ultimately require higher levels of care, the family intervention cannot be sustained within the community mental health setting.

Collectively, these issues speak to the challenges of implementing empirically supported, model-based care within the context of routine practice settings, specifically community mental health settings. Research can manipulate some of these factors. For example, future work could hire study therapists with extensive training in family therapy and significant practice experience and give them caseloads that would allow for weekly

treatment sessions. However, that would not represent or inform real world practice. In order for consumers to receive effective, acceptable interventions, the structure of community mental health care must undergo structural changes. Clinicians in the community mental health setting face current realities of high caseloads and never ending paperwork with arguably little compensation. This leads to burn out, and high turnover that limits the number of experienced clinicians practicing in this setting. All of these factors negatively impact consumers' experience and likely prevent them from improving. This is a social justice issue as the mental health service system in this country is failing to provide appropriate services to those consumers who are most vulnerable and have no other treatment options. Social workers engaged in mental health services researchers must work with policymakers in order to advocate for structural changes, including a shift in funding priorities that will allow for the effective implementation of evidence-based care within the public mental health system. As insurance providers continue to tie reimbursement to evidence based care, there likely will be more opportunities to collaboratively work toward facilitating change in this direction.

5.1 LIMITATIONS

The results of this study should be considered within the context of several limitations. When testing empirically supported interventions within the real world setting, it is difficult to randomly select participants and obtain acceptable control or comparison groups. This study did not randomly select participants, but rather allowed families presenting for child treatment to self-select. It is possible that families who wanted family therapy and were willing to participate in a study may be qualitatively different from families who did not want family therapy and from families who did want family therapy but did not want to participate in the study. As both mothers and children participating in the current study exhibited high levels of mental health needs at baseline, it may be that these families had more severe, complicated problems than other families initiating individual child treatment. This study did not utilize a comparison or control group, which limits the applicability of the study findings. While this work examined change over time, it was not possible to assess a direct treatment effect. The observed change over time in family therapy could have been influenced by the natural tendency for remittance over time or factors related to maturation.

This study also lacks generalizability. The study was conducted in one semi-rural community mental health setting that put a high priority on delivering empirically supported treatment and was engaged in a long standing university-community collaborative research agenda. These conditions are not typical of routine practice settings. Further, the sample size for this study is small and lacks diversity. The small sample size in part reflects the fact that a large number of families who consented for the study did not meet the dose eligibility criteria ($n=23$; 42.5%) and of the 31 families

eligible for the study, 25% were lost to attrition. While these numbers are consistent with findings from other effectiveness studies conducted within routine practice settings, it does leave unanswered questions related to acceptability and sustainability. As community mental health settings serve diverse consumers, it is important for future work to examine the impact of family therapy on consumers of color.

Another limitation of this study is a lack of formal fidelity assessment. The qualitative findings provide a basic level of support for therapists' adherence to the standardized SFT model and identify some implementation challenges; however, there are unanswered questions about therapists' adherence to the SFT model as well as the adaptations for implementation. The limited understanding of model fidelity impacts our main study findings and has implications for replication efforts, as we cannot conclusively state that the model described was the exact model implemented. As effectiveness research progresses, implementation outcomes must be integrated with consumer outcomes.

Additionally, the children's outcome measures selected for this study were not the most applicable. As family therapy has the strongest empirical support for treating children's conduct disorders and ADHD, study measures should have overtly addressed these disorders. While the Columbia Impairment Scale offered an indication of general impairment, it was a rather blunt instrument.

Despite these limitations, the study has several strengths. This work answers the call for social work researchers to test empirically supported interventions within routine practice settings (Proctor et al., 2008; Mullen et al., 2003). There is a lack of research examining effectiveness of efficacious psychosocial treatments in routine practice

settings, which typically serves vulnerable populations. This work examined the effectiveness of family therapy, an empirically supported intervention, in routine mental health settings. The semi-rural setting of this study gives it added value as researchers and policymakers have historically ignored the mental health needs of rural women and families (Mulder et al., 2001). Further, the current research is only one of two identified studies that examines the impact of family therapy on mothers' mental health symptomatology in addition to child outcomes (Barkley et al., 1992). This work offers an innovative, empirically supported strategy to increase the engagement and well-being of mothers initiating treatment for their children in routine practice settings. These mothers typically have high levels of unmet need, yet represent a hard to reach population. The results of this pilot study provide a starting point for examining the utility of family therapy for mothers and children within routine practice settings, is an important addition to national agenda advocating effectiveness research, and provides useful implications for social work research and practice.

5.2 IMPLICATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

Implications for Practice

This pilot study, examining the effectiveness, acceptability, and sustainability of Structural Family Therapy in community settings, suggests that administrators and clinicians in routine practice settings should consider family therapy as a treatment when identifying and implementing appropriate, empirically supported interventions. The results of this study indicate that Structural Family Therapy is likely an acceptable intervention for mothers whose children present with mental health needs, and may provide a cost-effective way to engage and increase access to services for this elusive population. The study findings also suggest the clinicians within community mental health settings may require more skills to effectively work with families. Finally, the results questions the feasibility of implementing empirically supported, model based care given the current realities of routine practice settings, particularly community mental health settings.

The Structural Family Therapy model was specifically designed to address the needs of multi-problem, low-income families and appears to align with mothers' perceptions of mental health treatment. The results of this study suggest that SFT is both effective and acceptable for addressing the needs of mothers whose children present for community mental health treatment. Knowledge of patient preferences can increase access to care. Mothers whose children present for community treatment have been particularly hard to engage, as these mothers appear to view individual therapy as an unacceptable option. This study provides agency administrators and clinicians with an innovative approach for engaging these mothers.

In addition, Structural Family Therapy offers a basic, yet robust intervention that was designed to be easily trained and accessible to paraprofessionals. Agency administrators face increasing pressure to provide empirically supported interventions, yet choices are limited as few treatments have been tested in routine practice settings. Many well-established, manualized interventions require clinicians to complete extensive, expensive training that isn't practical due to funding constraints and high staff turnover common in routine practice. Further, clinicians demonstrate a preference for interventions that are easy to understand (Proctor, 2004). Therefore, SFT seems to align with the needs of providers and clinicians.

Structural Family Therapy may also provide a more cost effective treatment option for providers. The findings of this study suggest that SFT may have utility for concurrently treating multiple family members. With the known links between maternal and child mental health, family therapy would give clinicians the option, when appropriate, to see two or more family members with mental health needs together instead of scheduling multiple separate individual therapy sessions. Results further demonstrate that family therapy could serve as an important step-up to and step-down from more restrictive, intensive services and programs, which could also offer financial benefits.

Further, this work suggests that it is important for clinicians in routine practice settings to receive more skills needed to work with families. The hereditary nature of mental health needs as well as the demonstrated link between mothers' and children's mental health needs suggest that therapists could benefit from a greater understanding of families. The qualitative findings of this study specifically indicate that mothers gained

coping skills necessary to effectively manage their children and as a result were able to move their family toward more functional patterns of interaction. It is likely that enhancing clinicians' understanding of family development and incorporating it into parent meetings as part of individual child therapy may benefit mothers and children. As Family Development Theory offers many parallels to the Structural Family Therapy model, it may offer an important learning tool for both therapists and consumers. If family therapy is implemented within routine practice settings, it is crucial that clinicians have the qualifications and skills necessary to effectively work with families. In general, family therapy is difficult to practice and working with multiple family members may be intimidating, especially for less experienced clinicians. The findings of this study suggest that even the most motivated, credentialed therapists may have had difficulty implementing the SFT model and identifying children and families whose needs were appropriate for outpatient family therapy.

All of this study's implications for practice must be considered within the context of the community mental health setting. Results of this study led to questions regarding the feasibility of implementing and sustaining empirically supported, evidence-based care within routine practice settings. Even within a community mental health center that had a long-standing collaborative relationship with university researchers, there were considerable challenges to effectively implementing the SFT model. Agency administrators and clinicians must be aware of these challenges but also actively advocate for structural changes that will facilitate the use of evidence-based care in routine mental health service settings and ultimately ensure that the most vulnerable mental health consumers receive effective, acceptable treatment.

Suggestions for Future Research

This work has implications for additional research that is needed in the field. The current pilot study offers some support for the effectiveness of family therapy in routine practice settings, but also suggests the need for a broader research agenda examining family therapy in routine practice settings. To further the promising results of this pilot study while addressing some of the identified limitations, future work should focus on: 1) replication studies that incorporate more rigorous research designs and more diverse samples; 2) examining the impact of family therapy on all participating family members 3) the evaluation of the implementation process in addition to consumer outcomes; and 4) the development and evaluation of strategies to simultaneously address maternal and child mental health needs when empirically supported treatment is not available.

The results of this study suggest that Structural Family Therapy is effective for addressing mothers' mental health symptomatology in routine practice settings. However, analyses also revealed that SFT did not impact children's mental health symptomatology. The mixed support for study hypotheses suggest the need for further examination of family therapy within routine practice settings. Further examination of family therapy should be conducted with more rigorous research designs and larger, more representative samples. Researchers should move toward a research design that includes either a control or comparison group. In addition, future studies should include larger sample sizes that reflect the diversity of consumers seeking care in the real world. Larger samples would also allow researchers to gain an understanding as to whether family therapy works better or some families and whether it is more effective under certain conditions.

Qualitative results of this study, as well as the theoretical underpinnings of family therapy, suggest that all family members participating in treatment were impacted by the intervention. Mothers specifically noted the insight siblings gained into the presenting child's behavioral health needs and how that positively impacted future interactions as well as the lack of fathers' involvement and how that may have undermined the treatment. Additional research is needed to examine treatment outcomes for all family members, including those who attend and those who do not attend the family therapy sessions.

In the current study, qualitative interviews with participants provided insight to the implementation process and the sustainability of family therapy within routine practice settings. However, it is imperative to directly study the implementation process. The perspectives of clinicians and agency administrators are needed, in addition to consumer perspectives, in order to gain a comprehensive understanding of the ability to implement and effectively administer family therapy within routine treatment settings. Another important implementation issue to be considered is cost effectiveness. Many routine practice settings face funding constraints and need to justify the use of particular interventions.

Identifying the positive effect of time spent in Structural Family Therapy on mothers' mental health symptomatology provides an opportunity to develop and evaluate strategies that simultaneously address maternal and child mental health needs when empirically supported interventions are not available. As empirically supported interventions, such as family therapy, are typically not available to consumers seeking treatment in routine settings, there is an opportunity to develop clinical and community-

based interventions to address the link between mothers' and children's mental health needs. Results of this study suggest that mothers are able to learn and apply basic parental coping strategies that they believe positively impacts their stress level and ability to manage their child. This may be a particularly relevant strategy to engage rural mothers who exhibit a preference for informal care.

5.3 CONCLUSION

This mixed methods pilot study examined the effectiveness, acceptability, and sustainability of Structural Family Therapy for mothers and their presenting children in a semi-rural community mental health setting. Results suggest that mothers' mental health symptomatology and perceptions of their child's impairment improved with time spent in family treatment, while children's mental health symptomatology. Overall, mothers' functioning did not change with time spent in Structural Family Therapy, though it steadily improved over time. In addition, mothers' reaction to the family therapy suggests they found it an acceptable intervention as they reported gaining skills necessary to more effectively manage their child's behavioral health needs as well as strategies for their own self-care. Findings also gleaned insight to the implementation process, suggesting the inconsistency of care and the severity of children's behavioral health needs negatively impacted families' experiences with family treatment. Findings from this study suggest that family therapy may provide an innovative, evidence-based approach to engage and treat mothers with mental health needs whose children present for community mental health treatment. Additionally, findings from this study offer insight to implementation challenges within real world settings that may impact children's outcomes.

APPENDIX A

TREATMENT DOSAGE CHART

SFT ID	# Sessions BL-3M (Weeks 1-12)					# Sessions 3M-6M (Weeks 13-24)					DOSE ELIG.
	F	I	DNS	CBC	CBT	F	I	DNS	CBC	CBT	
1101	6	1	0	1	0	3	1	0	4	0	IN
1102	3	3	0	0	0	1	2	1	0	0	IN
1103	1	0	1	1	0	0	0	0	0	0	OUT
1104	4	3	1	1	0	3	2	2	1	0	IN
1105	2	8	3	0	0	1	1	2	9	9	IN
1106	4	5	0	0	1	1	0	2	1	0	IN
1107	2	1	1	2	0	2	0	0	1	0	IN
1108	1	2	1	1	2	0	2	2	1	0	OUT
1109	6	2	0	0	0	4	1	0	0	0	IN
1110	2	0	1	1	0	1	0	0	0	0	IN
1111	2	0	2	1	0	3	0	2	0	0	IN
1112	4	2	0	1	0	0	0	0	0	0	IN to 3MO FU
1113	3	1	2	0	0	4	2	1	0	0	IN
1114	7	6	0	0	0	4	2	1	2	0	IN
1115	2	1	0	1	0	1	1	0	0	0	IN
1116	3	0	1	0	0	0	0	0	0	0	IN to 3 MO FU
1117	1	2	3	0	1	0	0	0	0	0	OUT
1118	1	3	0	1	0	1	0	1	0	1	OUT
1119	5	2	0	1	0	1	1	0	0	0	IN
1120	5	0	0	0	0	4	0	0	0	0	IN
1121	1	0	0	1	0	0	0	0	0	0	OUT
1122	1	0	2	0	1	1	0	0	0	0	OUT
1123	2	3	0	0	0	0	7	1	0	0	OUT
1124	2	2	4	0	0	0	0	1	0	0	OUT
1125	2	0	0	2	0	0	0	1	0	0	OUT
1126	1	0	2	0	0	2	1	1	1	1	OUT
1127	10	0	0	0	0	6	0	1	0	0	IN
1128	2	0	2	0	0	1	3	2	0	0	IN
1129	1	1	0	1	0	0	0	0	0	0	OUT
1130	3	1	0	1	1	0	0	0	0	0	IN to 3 MO FU
1131	4	2	0	1	0	2	1	1	1	0	IN
1132	3	0	2	0	0	0	0	0	0	0	IN to 3 MO FU

1133	7	0	4	0	0	0	0	1	0	0	IN to 3 MO FU
1134	1	1	2	1	0	0	0	0	0	0	OUT
1135	2	0	3	0	0	0	0	0	0	0	OUT
1136	2	4	1	0	0	0	0	0	2	0	OUT
1137	2	3	1	2	0	1	4	0	4	0	IN
1138	1	0	0	0	0	0	0	0	0	0	OUT
1139	3	6	1	0	1	0	0	1	2	0	IN to 3 MO FU
1140	3	1	2	0	0	4	0	0	1	0	IN
1141	3	0	1	0	0	0	0	0	0	0	IN to 3 MO FU
1142	8	0	0	0	2	1	0	0	0	1	IN
1143	1	1	0	2	0	0	0	0	0	0	OUT
1144	1	0	0	0	0	0	0	0	0	0	OUT
1145	1	3	0	2	1	0	4	0	1	1	OUT
1146	2	0	1	0	0	0	0	0	0	0	OUT
1147	2	0	2	0	0	1	2	0	2	0	IN
1148	1	0	1	0	0	0	0	0	0	0	OUT
1149	2	0	2	0	0	0	0	0	0	0	OUT
1150	3	1	0	2	0	3	1	0	0	0	IN
1151	1	0	0	5	0	0	4	0	0	0	OUT
1152	2	0	0	1	0	3	1	0	1	1	IN
1153	2	7	1	1	0	0	6	1	4	1	OUT
1154	3	1	0	1	0	1	2	0	2	0	IN

Legend: F = Structural Family Therapy sessions
 I = Individual Therapy sessions
 DNS = client/family did not show for scheduled session
 CBC = client/family cancelled scheduled session
 CBT = therapist cancelled scheduled session
 Dose Elig. = Dose Eligibility for Study Participation

APPENDIX B

QUALITATIVE INTERVIEW PROTOCOL

Study Overview

We're talking to women like you who have experienced difficulties with a child and have brought the child to the clinic for help. We're interested in learning why moms decide to bring their children to the clinic. We're also interested in learning about the kinds of issues that families like yours face, and what the clinic can do to help make those kinds of issues better.

- I. I'd like to start off by having you tell me a story about what led you to come to the clinic 3 (6) months ago. I'm interested in hearing about the difficulties you were having with your child and what life was like for you and your family – what you were going through – around that time. You can start your story wherever you like and talk as long as you like, but tell me whatever you think is important in order for me to understand your decisions to bring your child to the clinic.

A. Child

- What did you think might have caused some these behaviors that you were seeing? [troubles at home, problems at school, etc.]
- Before you decided to come into the clinic, what other things had you tried to do – or had you thought about doing – to help deal with your child? Tell me a little bit about how you thought [remedy] would help.
- What changes – if any – have you seen in your child in the last 3 (6) months?

B. Mother

- Tell me [more] about what *your own* life was like 3 (6) months ago...How were *you* doing around this time?
- If you can, tell me about those things that happen day-to-day that seem to make [those feelings] **worse**.

- What kinds of things have you tried – or thought about doing – to make [those feelings] **better**?
- When you can into the clinic, did a clinician talk to you about how you were feeling?
- Were there other times in your life when you had felt like this? [if yes, and if necessary] What do you think caused you to have [those feelings] then?

C. Family

- How were the other members of your family doing 3 (6) months ago? Was anyone else having problems?
- What do you think was causing the kinds of problems you were seeing?
- What kinds of things did you try to help them feel better?
- Have you seen any changes in your family in the past 3 (6) months?

II. Key Question for Mom

Do you remember [the interviewer/clinician] saying that she/he thought you might be “depressed” or “anxious”?

IF NO

- Describe for me what you think about when you hear the word “depression” [“anxiety”] or that someone “is depressed” [“is anxious”].
- What kinds of things do you think people who are depressed/anxious might do in order to feel better?

IF YES

- What was your reaction when she/he said that to you?
- What did [the interviewer/clinician] suggest that you do to feel less depressed/anxious?
- What were your thoughts when she/he suggested that? [helpful, not helpful?]

1. IF NOT HELPFUL

One of the things we’re trying to learn more about is when people think that the services or treatment offered by the clinic will or will not be helpful.

- Tell me why you didn't think that the services would be helpful for you (probe for previous negative experiences with the service system).
- What kinds of things did you think would be *more* helpful?
- Help me to understand the difference between your child's situation and your own, that is, how you see the services offered by the clinic as being helpful to her/him, but not for someone like yourself?

2. IF HELPFUL BUT DID NOT FOLLOW THROUGH

One of the things we're trying to learn more about is why some moms might want services that are suggested, but are not able to actually get the services for themselves.

- What kinds of things do you think are getting in the way of your being able to (do suggested intervention)?
- What kinds of things do you have to overcome in order to bring you child to the clinic?
- [IF ISSUES ARE THE SAME] – Tell me a little bit about why you think you're able to make sure your child gets to the clinic for services, but you are still facing various barriers

III. Questions on Networks

A. **Positives:** Thinking about your life in general:

- Who are the people that you call on if you need someone to help you do something, [like transportation, money, childcare, or if you just wanted to talk]?
- And if you wanted to feel less depressed/anxious, who would you call on? (Assuming that this was not discussed earlier.)

B. **Stressors:** Conversely:

- Who are the people in your life that make it more difficult for you to do the things you want/need to do, [like get to the store, get to the clinic, etc.]?
- And are there people in your life you seem to make you feel more [depressed/anxious, stressed, etc.]?

C. **Summary for Networks**

- Who in your life do you think really understands you and your situation the best? [Tell me a bit about why you think that is.]

IV. Comparison Question

I'd like you to think for a moment about the kinds of things that you, your child [children], and your family have been going through lately. Because we're trying to better understand the experiences of families like yours, describe how you see the relationship between different family members who are trying to work through these kinds of difficulties.

V. Summary Question

Is there anything about your decision to bring your child into the clinic, or your own feelings, that I haven't asked about but that you think is important for me to hear in order to understand your experiences better?

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