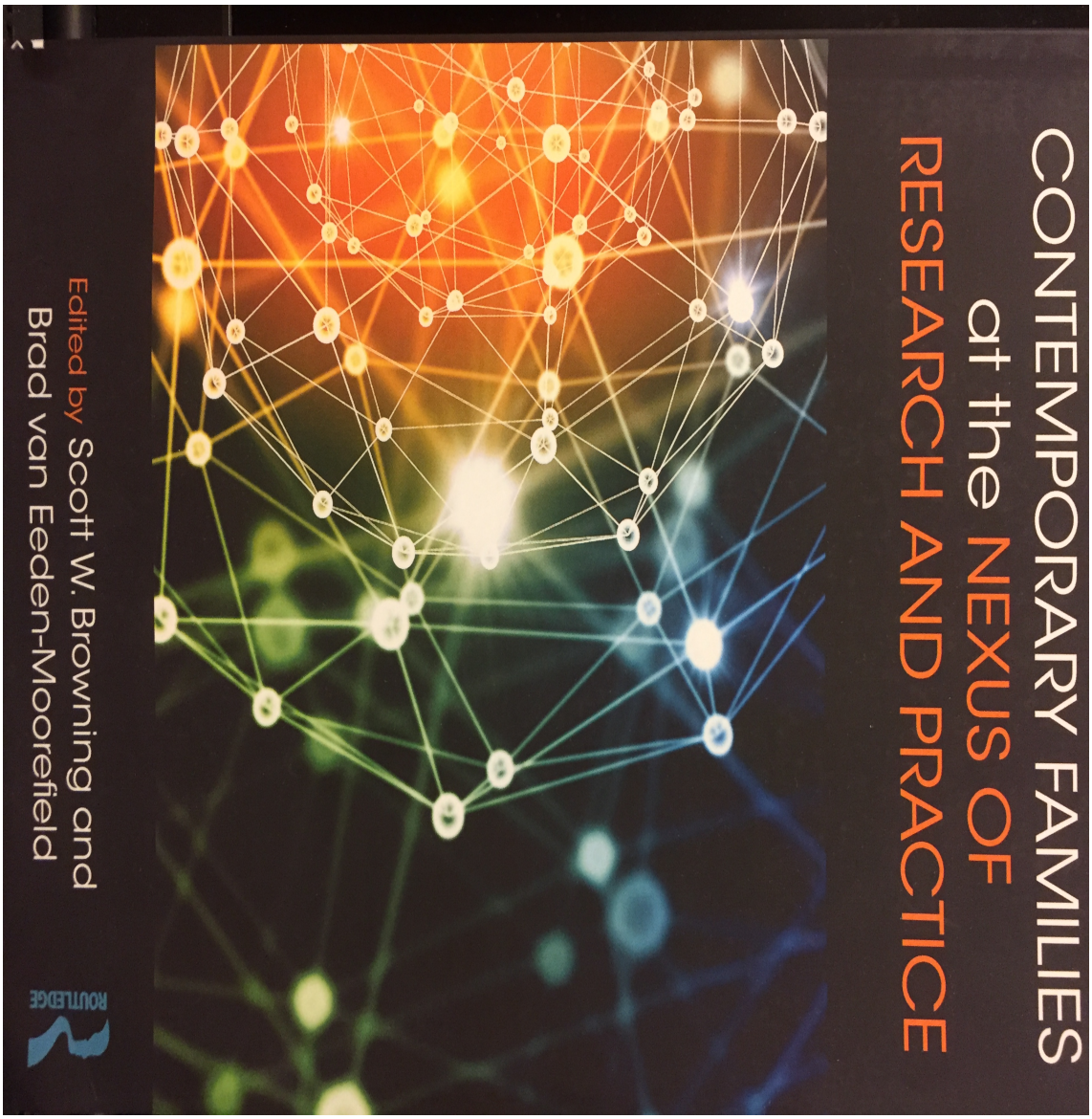


Citations

Jones, C.W. (2017). An Eco-Systemic Approach to Strengthening Fragile Families. In S. Browning & B. van Eeden-Moorefield (Eds.) **Contemporary Families at the Nexus of Research and Practice, Volume II.** NY: Routledge Press.

Tach, L. (2017). Research perspectives on fragile families. In S. Browning & B. van Eeden-Moorefield (Eds.) **Contemporary Families at the Nexus of Research and Practice, Volume II.** NY: Routledge Press.

Acknowledgment

A special thanks to Melissa Arment, a Program Director at one of Pennsylvania's Family Based Mental Health Services programs, for her important contributions to this case study.

Case Study

C. Wayne Jones

When 17-year old Marilyn was found by the police, after having been reported as missing by her mother, she was catatonic, naked and wrapped in a cover from a gas grill. She was having both visual and auditory hallucinations. She was hospitalized for a week, where she was stabilized, then referred to a local intensive in-home family-based mental health program. Although she was no longer showing psychotic symptoms at discharge from the hospital, she remained shut-down emotionally, voicing considerable hopelessness about whether anyone could help her.

Marilyn struck the in-home family-based team as bright, intense, sensitive, and emotionally overwhelmed. She had been cutting, sporadically using drugs (mostly pot), and withdrawing through excessive sleeping. Although previously an A-B student, she was failing many of her classes at school. She talked a lot about being lonely both in her family and at school. Marilyn told the therapists that she had run away from her home because her 18-year-old brother, Allen "puts me down and pushes me around." Although Marilyn is the identified patient in this case, the team noticed that both Marilyn's mother and her brother are equally distressed and symptomatic.

Marilyn's mother, Shelly, is divorced from the children's father. He lives across the country and is peripherally involved. Shelly is currently parenting alone and admits to being depressed, spending most days in her bedroom. She worries about Marilyn, but admits she is ready to throw in the towel on trying to parent her. She describes Marilyn as strong-willed and at times believes she may be "possessed." Disagreements between Shelly and Marilyn often escalate into dramatic shouting matches, pushing, and slamming of doors.

Caregivers in fragile families, like Marilyn's family, often present as alone, overwhelmed and exhausted by their lives, with little energy left to parent. Caregivers are in conflict and not working together, whether they live in the same household or in different households. The more challenging the child's problems, the more likely therapists will be met with pressure from caregivers to send the child to an out-of-home placement. This was the case in Marilyn's family. There was little glue holding the family together – the bonds were fragile.

Family History

Shelly has a history of extreme trauma, yet she has never had any mental health treatment that has linked any of her symptoms of distress to it. Shelly is the youngest of five. Her next youngest sibling is 12 years older. Her father was a World War II veteran and is suspected to have had untreated war-

related PTSD. He drank a lot, as did Shelly's mother. Her father would rage when angry and become violent. Although he physically abused all of his children (some also sexually abused), her mother seemed to get the worst of it. The beatings were severe. Shelly's mother decided she could no longer be a parent (around age 30) and placed all five of her children in an orphanage, 2 years before she was born. All of Shelly's siblings have struggled as adults with major mental health issues and substance abuse.

The story that Shelly has been told by her older siblings is that her mother did not want her when she was born and had said she would have aborted her, but discovered her pregnancy too late. Her mother died when Shelly was two years old from a brain aneurysm. She wonders if it was a result of the years of violence she had suffered at the hands of her father. From age two to four Shelly lived with several different people, finally being adopted by her older sister, Diane, at age four. Tom, her stepfather, sexually abused Shelly between the ages of 11 and 16. Shelly told a school counselor and an investigation ensued, which eventually resulted in her adoptive parents separating and divorcing. However, her adoptive mother to this day still blames Shelly for causing it all by dressing too provocatively.

At age 20, Shelly met Larry at Culinary School. When they graduated two years later, they moved in together and moved to the South, both finding jobs as chefs. Although they never formally married, they lived in one of 10 states in the US that still recognize an informal hand-written signed note that states, "we intend to be a married couple." This is known as common law marriage. Shelly wanted this as "relationship insurance." Shelly describes their first six years together fondly; she felt "normal." They had fun together, went camping, traveled some, and had friends. All this began to change slightly after Allen was born, but changed substantially after Marilyn's birth. Larry says Shelly's personality changed once she became a parent, becoming more disorganized, not taking care of her daily hygiene, and behaving in a self-righteous manner. Shelly says Larry became more critical and distant. They started to fight frequently.

Larry describes his childhood and his family in mostly positive terms, with his mother being the one in charge of parenting since his father worked a lot. Although Larry's family does not seem to have the same level of abuse and trauma as Shelly's family, the family-based team felt that Larry was overly sanitizing his background to a great extent.

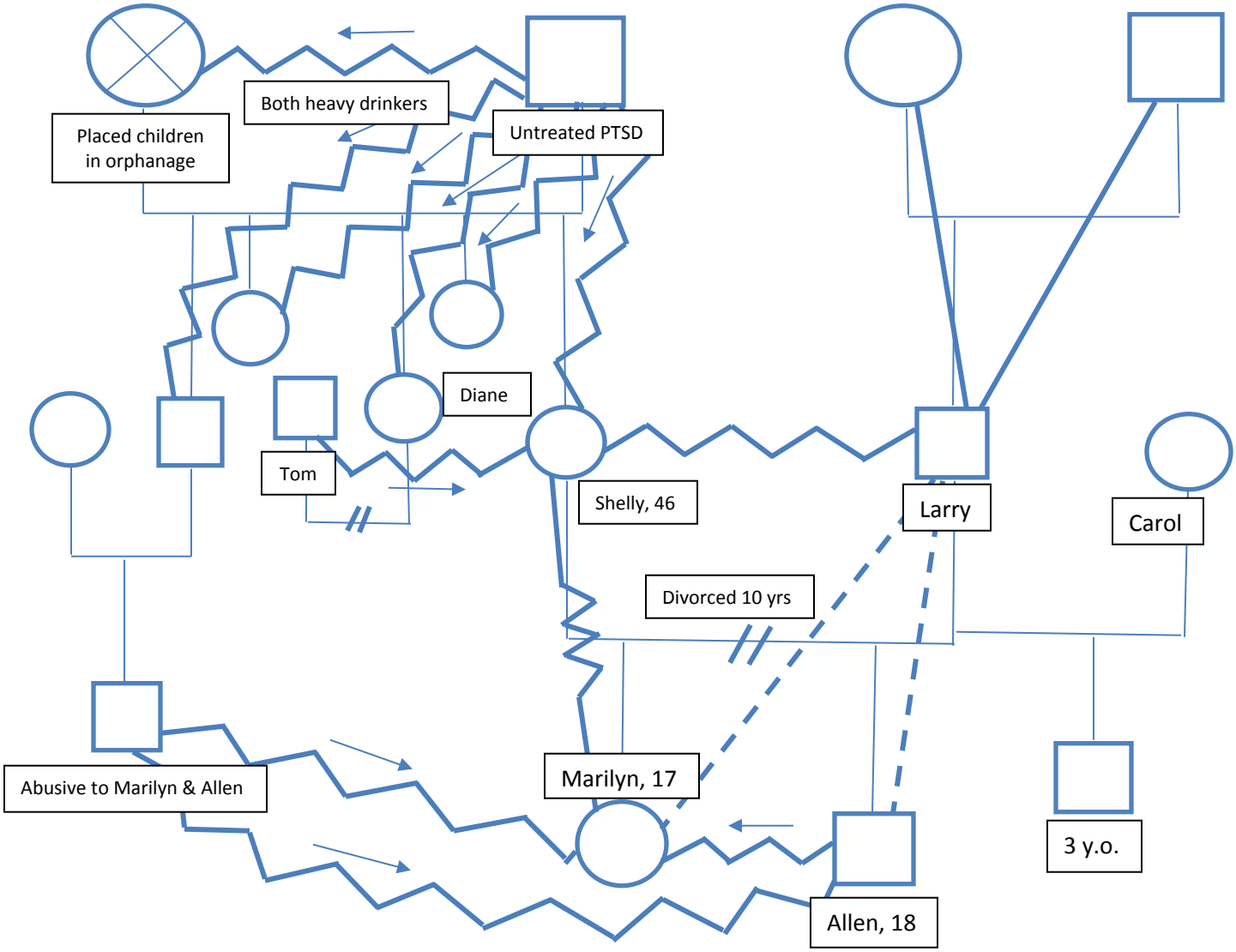
Shelly pushed for the family to move back to the Northeast to be closer to her extended family, hoping that they could support her as a young mother. Larry was reluctant but agreed to give it a try. Not only were Shelly's extended family not as supportive as she had hoped they would be, her young

children ended up being sexually abused by her brother's son. They cut off all contact with this family after this incident.

Twelve years into the relationship, Larry found a job on the West coast and moved out. Marilyn was 10 years old and Allen was 11. Shelly says she was devastated and notified the courts of their common law marriage, which meant Larry would have to go through a formal divorce process. Shelly refused to cooperate with the divorce process until granted full physical custody of the children. At about the same time, the sibling relationship deteriorated and they began fighting frequently. Marilyn says that Allen would beat her up and her mother would ignore it, implying she probably deserved it. Larry, her father, was physically and emotionally unavailable. Marilyn did not have close relationships with extended family because their family had cut-off from them.

Since the divorce, Larry has fared much better in his life than Shelly, with respect to income and friends. He has had several short-term girlfriends, marrying four years after he left Shelly to a woman who is 15 years younger. They now have a three-year-old son. Shelly's life has gradually become narrower and emptier since Larry left the home. Shelly has had a few dates, but nothing very serious since the divorce.

Allen and Marilyn have pretty much raised themselves alone since their father left. Allen, however, acts like it does not bother him; instead, he stuffs it (he is significantly overweight). Since he does not complain to Shelly and listens well, this has earned him favored status. Marilyn, on the other hand, is painfully aware of her suffering and dramatically complains about it, further alienating Shelly and making her an easy target for scapegoating. Allen thinks he is helping his mother when he "disciplines" Marilyn when she is being difficult. He does not see it as aggressive. This parentified role that Allen plays in the home will need to be addressed firmly and quickly, given that this was the trigger for the most recent treatment episode.


Placed children in orphanage
Both heavy drinkers
Untreated PTSD
Diane
Tom
Shelly, 46
Larry
Carol
Divorced 10 yrs
Abusive to Marilyn & Allen
Marilyn, 17
Allen, 18
3 y.o.

Research Perspectives on Fragile Families

Laura Tach

Fragile families like Marilyn's are defined by their economic and relationship insecurity, which leave them at a high risk of breaking up and living in poverty. Although poverty always has been a feature of the American economic landscape, socioeconomic inequality in family life has grown sharply over the past half century. Children born to the most educated parents have gained resources, whereas those born to the least educated have become more likely to experience unstable families and finances (McLanahan 2004). In this chapter, I discuss research on how "fragile families" form, the experiences of insecurity that tend to befall them, and how these experiences shape family relationships and wellbeing. Although Marilyn's case may seem extreme with respect to the intensity and duration of trauma, her story illustrates common themes in the research literature. I conclude with a discussion of ways in which policymakers and practitioners can harness this research to support fragile families.

Childbearing in Fragile Families

There is a strong socioeconomic gradient in the timing and relationship contexts of childbearing. Today, women and men with low levels of education are substantially more likely to begin their childbearing early and outside of marriage than their college-educated counterparts. According to nationally representative data from the National Survey of Family Growth (NSFG), becoming a parent during young adulthood (before age 25) is the norm for men with a high school degree or less (52.6%), and is nearly ubiquitous for less-educated women (81.5%). Alternatively, parenthood during young adulthood is rare for college-educated women (25.1%), and almost nonexistent for college-educated men (6.1%; Edin & Tach 2012). Early childbearing is often nonmarital childbearing: a majority of young-adult mothers (65%) and fathers (60%) were unmarried at the time of their child's birth, and the share of births outside of marriage among teen parents is over 80% (Edin & Tach 2012; Hamilton et al. 2009).

Parents who have children at young ages and outside of marriage tend to exhibit a number of economic, psychological, and relational risk factors. Many have insecure attachments to work, low and unstable earnings, and histories of welfare receipt (Sum et al. 2011). Much of what we know about the personal and family characteristics of unmarried parents comes from the Fragile Families and Child Wellbeing Study, a longitudinal survey of children born to unmarried parents in large U.S. cities. In this survey, about one quarter of young-adult fathers who had children outside of marriage were not employed when their child was born and their average annual earnings were $16,000. Young-adult mothers did not fare much better: over half did not have their high school diplomas, and 40% were

receiving public assistance at the time of the child's birth (Edin & Tach 2012). Many parents also have health issues that make it hard to sustain work and family obligations. In fact, 17% of new unmarried mothers and 12% of unmarried fathers reported depressive symptoms in the year after their child was born, rates twice as high as their married counterparts (McLanahan 2009). Unmarried fathers were also twice as likely as married fathers to have problems with drug use, three times as likely to be violent, and nearly seven times as likely to have been incarcerated in the past (McLahanan 2009). It is within these circumstances that couples conceive and give birth, forming what researchers call fragile families.

The romantic relationships that produce fragile families tend to be haphazard and casual. Unmarried parents' qualitative accounts of their relationships reveal that the median length of relationship prior to conception is only 6 to 7 months, and fully half described their relationships prior to conception as casual (Tach & Edin 2011; Edin et al. 2007). According to NSFG data, most unmarried parents (74%) report that their child's birth was unplanned (Finer & Henshaw 2006). Pregnancy intentions are difficult to measure, however, and qualitative research suggests that most pregnancies to unmarried parents are neither fully planned nor fully avoided. Many reported an ambivalent desire to have children and inconsistent contraceptive use (Augustine et al. 2009; Edin & Kefalas 2005; Waller 2002).

Despite rapid progression to childbearing, most who form fragile families are optimistic about their prospects as parents and partners. Most fathers readily acknowledge paternity rather than contest it (Edin et al 2009; Waller 2002), and many eagerly embrace the role of father (Augustine et al 2009; Edin & Nelson 2013). In the Fragile Families survey, three fourths of unmarried fathers offered financial support to the mother during her pregnancy, and seven in 10 visited the mother and child in the hospital (Edin & Tach 2012). Nationally, fully half of children born outside of marriage are born to parents who are cohabiting, and another third are born to parents who are romantically involved but not living together-- just 20% occur to parents who are not romantically involved with one another (Tach & Edin 2011). Thus, while being married is not the norm for disadvantaged parents, being in a romantic relationship is. Further, at the time of their child's birth couples reported that they were optimistic about their future together, including the possibility of marrying (Center for Research on Child Wellbeing 2003). This has led researchers to dub the time of the child's birth as *the magic moment* for fragile families – a moment full of optimism and commitment, and one with potential for intervention and outreach.

Dynamics of Insecurity Factors among Fragile Families

Economic Insecurity

Children thrive in stable, secure environments. A host of research across economics, sociology, and psychology has documented the ways in which relationship instability and economic insecurity create chaos in the home and undermine children's cognitive and socio-emotional development, with lasting effects that persist into adulthood (for reviews, see Evans 2004; Shonkoff 2010). The interdisciplinary body of research that has emerged to identify how poverty produces adverse outcomes clearly shows that poverty is a multi-level phenomenon that shapes a child's *macro-environment* via access to broader structures of opportunity such as quality schools, services, housing, and neighborhoods, as well as the child's *microenvironment* within the home, including the quality and stability of relationships with parents, parenting style, and learning materials (Bronfenbrenner 2009). Accordingly, newer poverty research often focuses on: identifying the precise causal effects of particular modifiable factors, understanding how these effects vary based on the developmental timing and duration of a child's exposure to poverty, and uncovering the bio-social mechanisms that link environmental exposures to adverse outcomes for children. These innovations will help identify particular sources of risk and resilience, as well as promising levers for interventions.

A major concern in poverty research is whether the effects of poverty are causal: is low income itself responsible for adverse child outcomes, or is this association produced by other parental characteristics that result in both low incomes and poor child outcomes? The answer to this question is important from a policy and intervention standpoint because it tells us which environmental or personal conditions to target. Among the most careful analyses of the causal effect of poverty on children's outcomes is the New Hope Study, a policy experiment fielded in the mid-1990s in Milwaukee, Wisconsin that raised parents' income by offering cash and in-kind assistance in exchange for employment. Led by the economist Greg Duncan, a team of researchers fielded a randomized experimental evaluation of the New Hope program and found that children of participants in the experimental group performed better in school and had fewer behavioral problems compared to controls (Duncan et al. 2007). Other quasi-experimental evaluations of cash transfers to poor parents have identified similar positive effects on children's health and educational achievement (Dahl & Lochner 2012; Hoynes et al. 2015). These studies reveal that not only does poverty have a causal effect on children, it is also a factor that can be modified to improve parental and child wellbeing.

Careful analyses of the dynamics and developmental timing of poverty revealed the experience of poverty is particularly detrimental during early childhood and when spells of poverty are of long

duration (Brooks-Gunn & Duncan 1997). Researchers also examined the adverse effects of economic insecurity – unexpected and/or involuntary fluctuations in income—on parenting and child outcomes (see Western et al. 2012 for a review). Unstable incomes produced by job, housing, and family instability increase parental stress and hinder parents' ability to plan for and invest in the future, which undermines their investments in their children. This body of work points to the dynamics of poverty that matter most: early developmental periods, long durations, and unpredictable fluctuations are particularly pernicious forms of poverty, and thus may be particularly effective moments for intervention.

Researchers also made strides in identifying biosocial pathways by which extreme stress and material deprivation affect brain functioning in children. Prenatal and early-life experiences of stress are thought to reduce a child's stress reactivity, due in part to epigenetic modification of gene expression and the alteration of developing neural circuits that control responses to stress (see Phillips & Shonkoff 2000 for a review). Although short-term reactivity to stress is advantageous, prolonged exposure can wear on one's organs, leading to poor physical and mental health – what researchers have dubbed *toxic stress* (Shonkoff et al. 2012). Because these early-childhood exposures can have lasting repercussions, researchers and practitioners interventions targeting toxic stressors associated with poverty could be effective in reducing socioeconomic inequalities as well as inequalities in mental and physical health during adulthood. Taken together, these emerging areas of research reinforce that the deleterious effects of poverty have lasting biosocial consequences, especially when experienced during early childhood, but that these effects can be mitigated via social policies.

Family Insecurity

Unstable family relationships are an additional source of risk for children born to low-income, unmarried parents. Although most parents who form fragile families are optimistic about their relationships, these relationships are typically quite unstable. For example, almost 40% of urban unmarried parents ended their relationships within a year of the child's birth and fully two-thirds had ended by the child's fifth birthday (Tach & Edin 2011). There are stark socioeconomic gradients and racial inequalities in the experience of family instability. Cohabiting and marital unions are less stable for low-income and Black couples than they are for affluent and white couples (Manning et al. 2004; Graefe & Lichter 1999). Risky behaviors like drug use, alcohol, smoking, and domestic violence are among the most common reasons couples cite for ending relationships (Reed 2007; Wilson & Brooks Gunn 2001; Waller & Swisher 2006). As a result, a majority of children in these families see their parents' unions end by their fifth birthday.

Not all non-marital unions end in dissolution. A handful remain stably cohabiting, and almost a third transition to marriage (Tach & Edin 2011). In-depth qualitative research reveals that standards low-income unmarried parents have for marriage closely resemble those their middle-class counterparts hold, even though their chances for meeting them are far lower. For the typical low-income unmarried father or mother, a prerequisite for marriage is a set of financial assets that demonstrate that the couple has "arrived" economically. Most say that before they can marry, they need a mortgage on a modest home, a car note, furniture, some money in the bank, and enough left over for a wedding. Without these marks of financial achievement – often called the *marriage bar* by researchers – it would not be right to get married (Edin & Kefalas 2005; Gibson-Davis et al. 2005).

Clashing with the reality of poor economic prospects, these standards lead to an indeterminate delay in marriage for many couples (Gibson-Davis et al. 2005). Marriage is more likely if a couple is able to improve their economic prospects, while becoming poorer decreases the likelihood of marriage (Osborne 2005). Men's economic standing is particularly important, and those with less education, low earnings, and weaker attachment to the labor force are especially unlikely to marry (Goldstein & Kenney 2001; Manning & Smock 1995). On an aggregate level, the concentration of economic disadvantage within particular communities, above and beyond one's personal characteristics, reduces the availability of suitable marriage partners and may influence marriage rates among disadvantaged populations (McLanahan & Watson 2009; Wilson & Neckerman 1986).

Incarceration is another form of family insecurity that is deeply implicated in the romantic relationships of fragile families, particularly for African Americans (Western & Wildeman 2009). Incarceration undermines relationships via men's absence from the family and the community, the logistical problems of visitation, and the shame men feel as a result of their incarceration (Edin et al. 2004b; Roy & Dyson 2007; Waller 2002). Men's absence during incarceration, for example, imposes both economic pressures and opportunities for women to move on to new partners. Even when this does not occur, the physical separation and lack of ability to monitor one another's behavior fuels suspicion and mistrust (Edin & Kefalas 2005). Partner relationships are marked by confusion and conflict during the period of incarceration, and deteriorating commitments between partners persist after men are released (Roy 2005).

Among couples that end their relationships, transitions to new romantic relationships occur quickly. Almost two-thirds of mothers who end their marriages, and over three fourths of mothers who end their cohabiting relationships, had a new romantic partner by the time their child was five years old (Tach & Edin 2011). Many even had two or more different partnerships during that time period, what

researchers call *churning* (Giordano et al. 2012). And new relationships can produce additional children, resulting in a proliferation of step- and half-siblings. Among recent cohorts, about one-third of children spent time in a stepfamily (Bumpass, Raley, & Sweet 1995), and 20 percent of women and 16 percent of men had children with more than one partner by midlife (Dorius 2012; Guzzo & Furstenberg 2007a; Guzzo 2014). Complexity is even more widespread among economically disadvantaged and racial minority families, where the prevalence of multiple-partner fertility approaches 50% (ibid). This combination of relationship instability and childbearing with multiple partners results in exceedingly complex family structures, with children experiencing two, three, or even more different father figures and a host of different resident and non-resident half-siblings.

Parenting and Attachment Insecurity

Unstable family structures have the potential to undermine child wellbeing, but they do not always do so. Although there is a great deal of political and empirical debate around the effects of family structure, studies using a range of methodological techniques (e.g., growth curve models, sibling fixed effects, propensity score matching) to identify causal effects tend to find significant negative effects, on average, of family instability for children's cognitive and behavioral outcomes (see McLahanan et al. 2013 for a review). Amato and Anthony (2014) examined heterogeneity in the effects of divorce and found that a nontrivial share of children experienced no observable negative effects of divorce on the cognitive and socioemotional outcomes measured. Similarly, Musick and Meier (2010) found that the effects of divorce were weak or nonexistent when parents had low-quality relationships prior to dissolution, suggesting that not all divorces necessarily undermine children's well-being.

Research has attempted to elucidate the mechanisms by which unstable family structures affect parental and child wellbeing. A key theme in this regard is the idea of attachment insecurity: the fragile nature of attachments among parents, partners, and children leave them vulnerable to emotional and relationship problems. From qualitative work and a growing body of research using the Fragile Families and Child Wellbeing survey, we know that parents' often-scarce resources of time and money must be spread across several households in complex families systems, and this presents a challenge to maintaining meaningful involvement with all of the households to which they may be obligated (Tach, et al. 2014). Furstenberg and his colleagues suggested that parents' priorities might shift as they move from one family to the next, taking on commitments and obligations with a new romantic partner (Furstenberg & Cherlin 1991; Furstenberg & Harris 1992). Fathers visit their nonresident children less frequently (Carlson & Furstenberg 2007; Tach, et al. 2010) and provide less economic support to them via formal and informal arrangements (Manning & Smock 2000) when they have children with new

partners. Parents with children in different households are also less intensively involved with their current residential children (Carlson, McLanahan, & Brooks-Gunn 2008), creating strain on current family relationships (Carlson & Furstenberg 2007; Hill 2007; Edin, Tach, & Mincy 2009). Prior partners, who often continue to engage with the mother via child visitation, are a significant source of tension in new couple relationships as the prior partner's visits can fuel jealousy (Hill 2007). Harknett and Knab (2007) also found that parents' kin networks provide less social support to them when they have children by other partners.

Maintaining high quality relationships between the mother and father is crucial for the intensity and quality of fathers' involvement with their children, both in the context of romantic relationships and after those relationships have ended (Carlson & McLanahan 2004; Furstenberg & Cherlin 1991). In other words, good partners are likely to make good parents (Carlson, McLanahan, & Brooks-Gunn 2006). Cooperative coparenting – the ability of mothers and fathers to actively engage with one another in order to share childrearing responsibilities (Furstenberg & Cherlin 1991) – is relatively uncommon, but it predicts more frequent and higher-quality father-child contact (Sobelewski & King 2005). Custodial mothers play an important role as "gatekeepers," either facilitating or hindering a nonresident father's involvement (Buchanan, Maccoby, & Dornbusch 1996), and mothers are more likely to grant access when the two have a strong relationship (Waller & Swisher 2006). Thus, interventions to support effective coparenting, especially when parents are no longer in romantic relationships, may help promote continued, high-quality relationships between fathers and their nonresident children.

The formation of stable, secure attachment relationships with caregivers during childhood is important for the development of healthy relationships throughout the life course (Hazan & Shaver 1987). The less committed, volatile relationships among members of unstable families make it more challenging for children to develop secure attachment relationships with their caregivers, and may have lasting effects on their ability for form secure relationships when they become adults (Stanley et al. 2010). In this way, children who grow up in fragile families are more likely to form fragile families themselves when they become adults (Musick and Mare 2006), contributing to the reproduction of family inequality over time.

Conclusions

Increasingly, researchers have attempted to consider the host of insecurities and risk factors that affect the family environment under the term *chaos:* the disruption of daily activities and the feelings that such experiences engender (Fiese & Winter 2010). Family chaos is more common among

economically disadvantaged families, and is particularly sensitive to residential mobility, nonstandard work schedules, and unreliable child care settings (Repetti & Wang 2010; Corapci 2010). Researchers have found that chaos leads to lower levels of investment in family relationships and parenting, with families spending less time together to establish and maintain family rituals and routines that are linked to positive relationships (Fiese & Winder 2010). Parents in chaotic settings are less responsive, more authoritarian, and invest less money and time in their children (Evans 2004). The new frontiers of research in this area offer some nuance to these findings—there is considerable heterogeneity in children's reactions to stress, which are shaped in part by biological risk factors, but stressful life events are particularly detrimental when they happen during early childhood and over sustained periods of time.

U.S. social policy and service delivery are not well equipped to address the needs of fragile families living in chaos, however. Most social policies either fail to recognize fragile families in the determination of benefits or penalize parents for not sharing biology or residence with their children. For example, SNAP (food stamps) allows only one household to receive benefits for a child. Similarly, the Earned Income Tax Credit (EITC) offers a substantial refundable tax credit for custodial parents and little for non-custodial parents. The all-or-nothing structure of both policies ignores the fact that many children in fragile families spend time in multiple households and with multiple parental figures. The current system, thus, has the potential to undermine the material resources available to children in fragile families, to increase within-family inequality by rendering children in the same family system eligible for different benefits, and to stigmatize them in the determination and recertification of eligibility.

In a similar vein, fragile families struggle to receive coordinated, high-quality physical and mental health services. They are less likely to be insured or to have a regular source of care, are more likely to forego treatment because of cost, and are less likely to receive timely preventive services (NCHS 2012). Their lives present a number of logistical barriers to receiving stable care, including a lack of access to transportation, and difficulties making and keeping appointments because of unpredictable family and employment circumstances (Diamant et al. 2004). Although there is little national research documenting disparities in the quality of services, qualitative case studies suggest that poor individuals can receive lower-quality care from practitioners due to a lack of provider understanding of what it is like to live in poverty. Further, this can manifest itself via a failure to collect adequate data about patients' social circumstances, the development of care plans patients are unable to follow, and a lack of awareness of social and community resources that could benefit patients (Bernheim et al. 2008; Willems

et al. 2005). In this way, contemporary social policies and services typically have failed to recognize the fluidity of resource, relationships, and living arrangements within fragile family systems.

The research evidence on the costs of family instability are painfully evident in Marilyn's case. Her mother, Shelly, experienced a series of troubled relationships with parents, relatives, and the foster care system as a child. As an adult, she struggled to form secure and stable relationships with her community, family, and treatment team. Shelly is now recreating the insecurity of her childhood with her own children, Allen and Marilyn, who each present the socioemotional consequences of their insecure family attachments in distinct ways. At the same time, Marilyn's case reveals areas where research evidence is lacking. There is little nationally representative data on rates of mental health issues and trauma among fragile families, the role of undertreated mental health problems in family formation, functioning, and dissolution, or the accessibility of quality mental and physical health services. These are ripe areas for future research that would advance our scientific understanding of the social determinants of health, improve service delivery among practitioners, and enhance the early detection and treatment of health problems among children like Marilyn.

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An Eco-Systemic Approach to Strengthening Fragile Families

C. Wayne Jones

In the previous section, Tach focused on the unique risks and challenges faced by fragile families, a family structure associated with frequent chaos and more often than not, poverty. This chapter focuses on the emotional and relational lives of fragile families, with special attention given to the role of emotion dysregulation and attachment insecurity in undermining family stability and the mental health of family members. Although fragile families may care about one another, minor conflicts easily escalate into major conflicts, abrupt family breakups, violence, and trauma. It is not surprising that the vast majority of children and adolescents showing Severe Emotional Disturbance (SED) treated in community-based behavioral health programs live in fragile, multi-stressed families.

SED is characterized by extra-sensitivity to stress, under-regulation of emotions, and a tendency toward severe and extreme reactions when upset (Jones, 2010). Without effective treatment, these children accumulate repeated failures in their lives and become the creators of the next generation of fragile families. For example, children with SED have the highest drop-out rate of all recognized disabilities under IDEA (Lehr, Johnson, Bremer, Cosio, & Thompson, 2004). Of those who graduate, only 30% do so with a standard diploma (Reimer & Smink, 2005). Twenty percent are arrested once before leaving high school and 50% are arrested within 5 years post high school (Davis & Vander Stoep, 1997).

Children and adolescents with SED often enter the behavioral health system at an early age, usually for disruptive behavioral problems. Most often, they receive treatments that focus strictly on symptoms, including psychopharmacology, behavioral management, and the teaching of coping or social skills. For those children who live in emotionally reactive fragile families, these interventions are rarely effective. These children cannot integrate new coping skills and sustain changes when their families are unstable and relationships insecure.

When children have multiple treatments and they do not feel their lives are any better as a result, they may give up on the possibility of change, concluding they are defective, and then become less open to further intervention. This is the mindset that Marilyn had when she came into treatment. The treatment team understood why Marilyn held this perspective. For several years in elementary school, she had *wrap around* services. This mostly involved a one-on-one person who helped her manage transitions and regulate her behavior in the classroom. Marilyn recalls that she did better in school with the extra structure and support, but that it did not help her feel better about herself because it did not change anything at home, where she felt unwanted. She also complained that every

time she started liking the workers, they would leave and be replaced with someone else. Before the service ended, she had four different workers. She also had a brief episode of outpatient therapy with someone she says mostly focused on helping her to identify and express her feelings. Marilyn told the team, "She was kind but she never really understood that if I express my feelings at home, my mother will just go crazy on me."

Marilyn had her first inpatient hospitalization at age 11 following suicidal ideation, not long after her father moved away. This began a six-year negative cycle involving the behavioral health system, Marilyn and her family. Marilyn would be prescribed medicine and outpatient therapy, would stabilize for a month or two, and then all treatment would stop leading to another hospitalization. There were six in all. The hospital functioned to regulate Marilyn when Shelly could not. Although some providers viewed Shelly's failure to follow-through with treatment recommendations for her daughter as neglectful and resistant, Shelly's response also could be viewed as a consequence of treatment that did not fully involve her as a partner. Providers gave her information about Marilyn's treatment but did not elicit her agenda or her perspective, nor did they assess the family context. Marilyn's father was not included at all. This acontextual, child-centric approach often is standard treatment of children with SED living in fragile families.

In this chapter, I describe Eco-Systemic Structural Family Therapy (ESFT), an evidence-informed approach developed specifically to treat children and adolescents with SED within the context of their fragile, multi-stressed families. I explain the treatment model and demonstrate its application using excerpts from the case study, identifying: 1) core vulnerabilities and negative patterns in fragile, multi-stressed families most associated with SED 2) how these core vulnerabilities shape the development of a therapeutic alliance, and the focus of treatment, and 3) the principles and methods of change. Finally, a detailed description is provided as to how ESFT was used with Marilyn and her family to help them make changes in each of the four core vulnerabilities targeted by ESFT. (Although this case study is based on an actual case, any information that might lead to identification of members of this family has been altered.)

A Brief History of ESFT

ESFT is an adaptation of Structural Family Therapy (SFT), developed by Salvador Minuchin (1974) and colleagues at the Philadelphia Child Guidance Clinic in the 1970s. It is grounded in systems theory, which assumes that what caregivers and their children feel, think, and do are a function of recursive relationship patterns in the family. These relationship patterns are, in turn, a function of the family's interactions with their extended family and the community in which they live. Most importantly in ESFT,

like SFT, treatment is strengths-based and collaborative, driven by a deep belief that most families, regardless of their circumstances or current problems, are capable of change with the right support. Therapists in this model are action-oriented and experiential, focused on identifying and then shifting negative relationship patterns in the family system to more functional ones.

Early formulations of ESFT were developed by Lindblad-Goldberg at the Philadelphia Child Guidance Center in response to an initiative by the Children's Bureau at Pennsylvania's Office of Mental Health and Substance Abuse in the late 1980s to create an intensive, in-home, community based family treatment program that would prevent children and adolescents with SED from cycling in and out of inpatient hospitals and residential treatment centers (Lindblad-Goldberg, Dore, & Stern, 1998). The SFT model was expanded so it could be team-delivered and more easily implemented in the home and community. Additionally, ESFT incorporates services such as parent education, service coordination, crisis intervention, family support, and case management.

ESFT became more integrative beginning in the late 1990s. Although still systemic at its core, the current clinical model incorporates more recent theory and research about the role of attachment, development, and trauma in shaping children and their caregivers' interactions with one another and the larger community, as well as their response to treatment (Jones, 2010; Jones & Lindblad-Goldberg, 2002). ESFT can best be described as an eco-systemic, trauma-informed, attachment-focused, developmentally-based family treatment program. The concepts and practices of ESFT were further specified and operationalized in a treatment manual published by Jones in 2010. The manual, together with a standardized clinical management system and measures of treatment adherence, have allowed the model to be more consistently implemented by community behavioral health providers, measure treatment outcomes, and study its effectiveness.

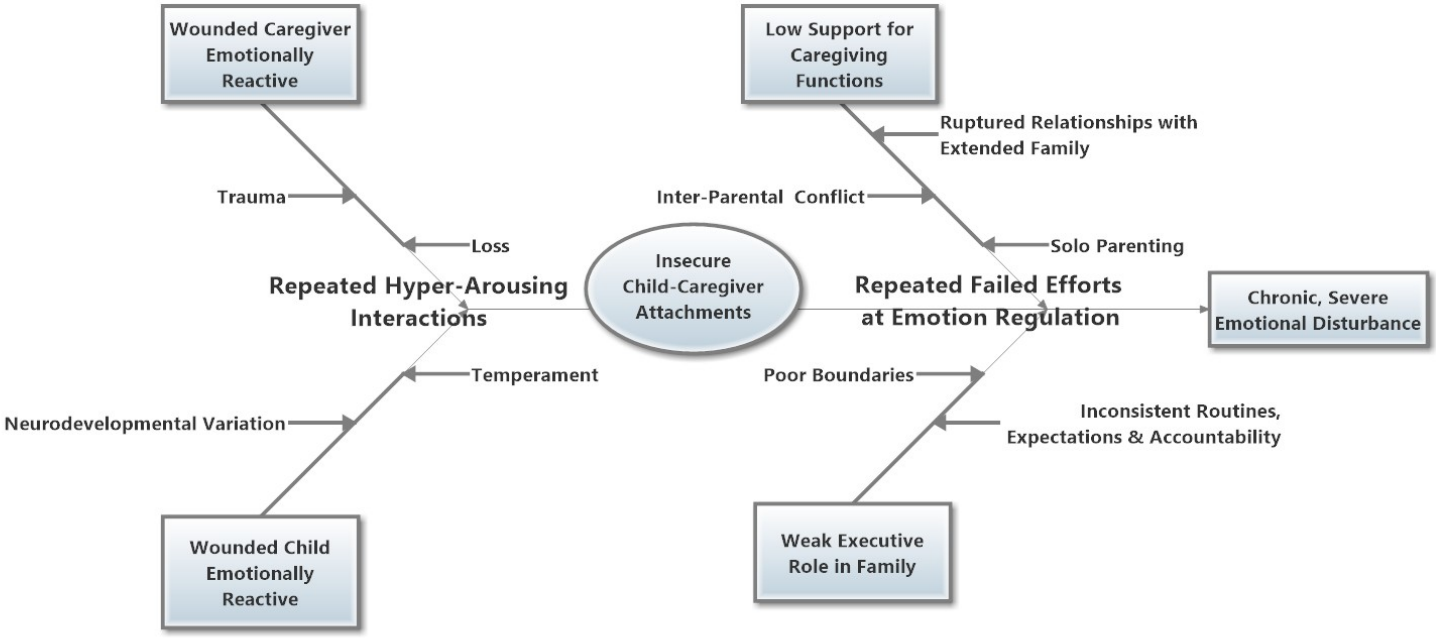
Core Vulnerabilities of Fragile Families with an SED Child

In ESFT, treatment is constructed around the observation that what causes and maintains SED symptoms is a family environment that is *hyper-arousing and under-supporting* (Jones, 2010). Although this can be found in any family across the socioeconomic, cultural spectrum, this is a particularly common situation in fragile families. At critical moments when a child needs comfort, calm, and connection most urgently, caregivers become activated and dysregulated by the child's emotionality, and then respond with name calling, yelling, withdrawal, threats of abandonment, and criticism. Family members are out of sync with one another's emotional needs at the most critical moments in their relationships with one another. The effect on everyone in an *SED System* is frustration and isolation, so communication becomes derailed easily, preventing resolution of routine conflicts.

In Marilyn's family, the core negative interactional cycle usually began with Marilyn distressed about peer conflicts at school, interactions with her brother, or anxieties about her studies. Marilyn struggled with regulating her attention and staying organized, which created considerable stress for her at school. Shelly would not notice her daughter's distress, often expressed as irritability, because she spent most of her time in her bedroom watching TV or reading her bible. Marilyn would try to handle her distress alone, playing her music loudly and smoking pot, but when this did not work, angrily barge into her mother's bedroom to criticize her for not cooking meals. Shelly, who belongs to a small evangelical church, would tell Marilyn that she was selfish and that her behavior was caused by the devil, and then she would begin praying and talking in tongues. This would send Marilyn into a rage, quickly sending her mother back into her bedroom and creating further distance and aloneness for both of them. These episodes would also activate Allen, her younger brother, who would take his mother' side and try to "punish" Marilyn for making their mother upset.

Although there is tremendous diversity among fragile families who have a child with SED, there are four general patterns they share that leave them vulnerable when they are in conflict or stressed (see Figure 4.1). First, caregivers are extra-sensitive to stress and have tremendous difficulty regulating their emotions when in conflict with their children and vice versa. This usually results in an insecure or ruptured caregiver-child bond since secure attachments are built on calm, soothing responses that bring relief from stress and anxiety. The family is then off balance when conflict occurs and they are unable to regulate or de-escalate the hyper-aroused family members. This is in part because the executive components of parenting are often weak and inconsistent. Caregivers tend to be overly harsh or not pay sufficient attention, and many times swing between these extremes depending on the mood or context of the caregivers on that particular day. Finally, the caregivers' relationships with one another and with those in their extended social network are organized in a way that undermines support for a non-reactive, positive approach to parenting. Caregivers need consistent emotional support and soothing themselves in order to give it to their children.

Insert here **Figure 4.1 Family Vulnerabilities and the Pathway to Chronic SED**



Implications for Creating a Therapeutic Alliance

The first task of any intensive, in-home family based treatment is to establish a balanced therapeutic alliance with all family members. In Marilyn's family, the therapists believed the most important person to connect with was Shelly. They recognized Shelly was extremely suspicious of outsiders so being invited into the home on a regular basis was going to be a struggle. Marilyn was equally challenging because she had given up all hope. For the first month of treatment, Marilyn withdrew to her room or left the house when they showed up. Since Allen believed all the problems in the family were Marilyn's fault, he also initially refused to participate.

The treatment team anticipated some initial defensiveness and guardedness, and they normalized it. They viewed it as an adaptation to what the family had experienced thus far in their relationships with other agencies, family-of-origin, and with one another. Shelly's experience with the service system to some extent mirrored her experience in her family-of-origin. That is, she felt a sense of failure and disempowerment. Shelly told the team that she had encountered a few service providers who treated her as a "bad" or "harmful" parent, uninterested in the welfare of her daughter.

The team had a negative internal reaction when Shelly stated angrily that she wanted Marilyn out of the home and was not interested in being personally involved in the treatment, but they did not judge her or react in the same way others had when they heard her talk in such a rejecting, hostile manner about her daughter. They reminded themselves that caregivers' initial presentations do not always accurately represent the full extent of who they have been in the past or who they are capable of being with more support. The team knew that no one looks their best when they are in crisis and are overwhelmed. This is when families are most likely to present with significant despair, chaos, and hostility. The team made it clear, however, that they would not recommend out-of-home placement and reminded Shelly how Marilyn's previous hospitalizations made it more difficult for Shelly to parent her.

No matter how strong the desire to be a good parent, untreated trauma, loss, and isolation can transform ordinary family conflicts into desperate fights for emotional survival, hijacking caregivers' executive potential to the point that their children, and sometimes even their partners, are perceived as the enemy. They are doing well just to survive, given their own high levels of internal distress. At times it can seem that childhood can be toxic to caregivers who are "wounded" by histories of complex traumatic stress and loss. This is certainly Shelly's history. She grew up with caregivers compromised by alcoholism, drug abuse, mental illness. Like many of the caregivers in fragile families, she also experienced harsh or abusive parenting, deprivation and neglect, sexual exploitation, and loss of an important caregiver at an early age.

In ESFT, the treatment flows through the caregivers. At first glance, this seems like an impossibility to therapists new to the model when they meet caregivers with major mental health issues like Shelly who are parenting alone and seemingly in no condition to take on such an active role. The treatment team addressed this dilemma by giving Shelly three important messages, all of which are essential in creating the therapeutic alliance and fully engaging caregivers in family treatment. First, they genuinely empathized with Shelly and acknowledged how overwhelmed she was. "This is an incredibly difficult situation and would be hard for anyone." The second message to Shelly was that Marilyn would recover more quickly if she knew her family was working just as hard as she was. "Marilyn needs to know that you are there and will be a major player on her recovery team … It would mean even more to her knowing how depressed you are." This message serves as an important value statement about the importance of families sticking by one another and begins a psychoeducational process about how change happens. "Marilyn can't fully recover from her illness without you." The third message that makes it easier to digest the previous one is that she will not be alone. "We are here

for you Shelly, we will work alongside you as a team every step of the way, doing whatever it takes to help you with your daughter."

Marilyn's trust of the therapists grew as she noticed how effectively and persistently they were working with her mother. Allen was very anxious about the therapists placing so much pressure on his mother because he anticipated she may deteriorate and things would be even worse for him in the home. He managed this anxiety by remaining in ear shot of the team's sessions with Shelly, slowly relaxing as he saw that the therapists were sensitive to his mother's emotional fragility. The team developed an alliance with Allen by taking care not to leave him out, checking in with him briefly after sessions with his mother and Marilyn, asking for his observations and acknowledging the role he has played in the family. He grew to respect their leadership abilities and agreed to fully participate in the treatment about two months into it.

An important principle here is, when caregivers are compromised and not fully participating in the parental role, the therapists' alliance with children is contingent on how effective they have been in creating an emotionally safe relationship with the caregivers. When therapists are successful in creating a collaborative partnership with the caregivers on behalf of the child, a relationship in which caregivers are credited for the strengths and assets they bring to the team, the alliance with both the caregivers and the children is established. To feel respected and to be listened to as collaborative partners is a new experience for many caregivers in fragile families with a history of having multiple community services. And, it is often a unique experience for children in these families to witness therapists treating their parents respectfully while holding them accountable. This is an essential part of setting the stage of effective treatment for any family, but for these families it carries considerable weight.

The ESFT Treatment Model

The overarching goal of ESFT treatment is to create a context within the family system that fosters greater relationship stability and greater emotion regulation, a context that is more growth-promoting and functional for its members. In short, a less fragile family. When therapists are successful, the child referred for treatment shows significantly reduced symptoms of distress, they are no longer a safety concern, and they are better able to handle the typical demands of participating in home, school and the community. Most importantly, caregivers come to believe they can manage and parent their children in their home. They are no longer talking about out-of-home placement. If caregivers do not have confidence in their ability to parent a child, the caregiver-child bond remains fragile and insecure, and the cycle of reactivity and rejection continues when caregivers become stressed by the child's behavior.

Insert here: **Figure 4.2 The Four Cornerstones (Drivers) of ESFT Treatment**

To create this outcome, ESFT therapists directly target the four core patterns that leave families vulnerable to dysregulation and chaos (see Figure 4.2). These are the cornerstones of ESFT treatment: 1) strengthen the co-caregiver alliance, 2) strengthen the caregivers' emotional availability to the child, 3) strengthen the caregivers' leadership role in the family, and 4) build support for the caregivers and the child in the extended family and community.

Core Mechanisms of Change in ESFT

In ESFT, there are six conditions (i.e., *mechanisms of change*) that, when present, are assumed to account for positive and meaningful change in fragile families with a child who has SED. Although the particular way in which these mechanisms are operationalized is specific to ESFT, they reflect common factors found in all current evidence-based family intervention models (Sprinkle & Blow, 2004). In the next section, the particular ways in which these conditions are created in ongoing treatment with Marilyn and her family are described. A therapist is fully implementing the ESFT model when they are working to establish the following six treatment conditions (known as the core mechanisms of change):

- *All family members who can influence the functioning of the child and the caregivers and their relationship with one another are included in treatment*
- *A strong therapeutic alliance is established between therapists and all family members*
- *Family members experience themselves as being part of a respectful, collaborative, and accountable relationship with therapists*
- *Family members experience themselves as safe, calm, regulated, and emotionally connected with one another in the presence of the therapists*
- *Negative, judgmental behavioral views of the child and one another are moving in the direction of a more compassionate, relational one*
- *Family members experience themselves as successfully practicing new, more functional patterns with one another.*

Setting the Stage for Change

Beginning with the first session, ESFT therapists work intensively to cultivate a treatment context where all of the above mentioned conditions are present. Therapists typically meet with families a minimum of three times per week (once with the identified patient alone, once with the caregivers, and once with the entire family), particularly during the first 90 days of involvement. They ensure there is full consent from caregivers to work on an agreed upon treatment plan. All initial operations of setting the stage are given equal weight. Together, these conditions create a treatment structure that stabilizes families and creates opportunities for meaningful engagement. To keep the treatment moving at a faster pace, ESFT therapists employ *strengths-based straight-talk* with families. In order for family members to hear therapists above the background noise of the chaos of their daily lives, therapists must be clear, focused, and persistent. The sixth operation, practicing more functional patterns, becomes the main focus of treatment once the stage has been successfully set. Below, the process for creating the stage for treatment with Marilyn and her family is described.

One of the more critical early tasks of ESFT treatment, but often most challenging, is engaging peripheral or uninvolved caregivers. Rather than passively accepting whoever shows up, the ESFT therapist works with the involved caregiver to elicit permission to contact the other caregiver. Marilyn and Allen's father, Larry, has lived on the other side of the country for the last seven years of her life. Shelly was cut-off from Larry after the divorce and does not speak with him about the children. Marilyn and Allen have sporadic phone calls with him. Not unexpectedly, Shelly firmly rejected the idea when the treatment team initially brought it up. She harbored significant resentments toward him for "abandoning" her and the kids. Marilyn also initially refused the therapists' request to contact her

father for similar reasons. Allen was okay with it, having maintained more contact with Larry than Marilyn after he left the home.

The team more strongly pushed the idea of contacting Larry during the next session when they were completing an Eco-Map of family members' connections with people outside the household and the kids included their father. The treatment team told Shelly that, "sometimes even a small connection with a father can be helpful to recovery, … your daughter is in real crisis here … why should you bear all the responsibility for her future mental health alone." Shelly remained reluctant because she feared the team would become influenced by negative things Larry might say about her. The team addressed this by reassuring Shelly, "No matter what Larry might tell us about you, we know you are the one that stayed with your children and faced the challenges of raising them alone." Marilyn softened in her opposition to involving her father a few weeks after her mother gave permission.

ESFT therapists are trained to be persistent in their efforts to repair cut-offs and re-establish some type of relationship with others who could possibly strengthen the caregiving system. In this case, the team knew that Shelly could not help Marilyn alone and their efforts would be limited without Larry's involvement. Larry eagerly accepted the call from the therapists, but it seemed that his initial agenda was to justify why he "had to leave" Shelly and the kids. Of course, Larry told the team many negative things about Shelly, many of which turned out to be true, but were not relevant to the task of helping his daughter in the present. He was reluctant initially to become involved in an ongoing way with treatment. The team's clarity with Larry about the importance of his role engaged him, giving him a purpose. By engaging Larry in treatment, even if long distance, the team had begun to develop an executive team, and had seeded the idea of at least some minimal co-parenting.

The team's success in engaging Larry had the effect of deepening their alliance with both Shelly and Marilyn, because it was the first time anyone they had worked with showed this level of potency. Another important set of early actions by the team that deepened their alliance with the family had to do with creating emotional safety, providing an experience for mother and daughter that it was possible to talk to one another in sessions without emotions escalating into a yelling match. They interrupted and shifted the direction of the conversation when Marilyn began cursing at her mother in sessions, which she had a strong penchant for doing. The team also interrupted and shifted the conversation when Shelly began to talk about Marilyn's behavior as being caused by demon possession. Early on they did not challenge this belief because it was deeply held. However, they established strong boundaries around bringing it up when they were doing family sessions, pointing out that it makes her daughter

stop listening to her and only increases her cursing. The treatment team brought in something new to the family – consistent structure, along with a calm and a nonjudgmental presence.

The next critical set of tasks in setting the stage for treatment involves softening the caregivers' negative, behavioral views of the child, and moving all family members towards a more compassionate, relational frame of the problems they are wanting to resolve. This requires developing some awareness on the part of family members that they are a system. When families are in crisis or living in survival mode, they usually do not pause to reflect on how they mutually affect one another. Their perspective is narrowly focused on sorting people into allies or adversaries. Many of the techniques used in ESFT are designed to help family members become more aware of themselves as a system of mutual influence.

Two informal process-oriented methods used for this purpose involve therapists 1) calling attention to and highlighting an interaction occurring in the room that seems to be part of a recurring pattern and then 2) punctuating the link between this interaction and either the problem or its solution. Therapists do not have to interpret or explain what is happening. Instead, therapists help ensure that family members attune to what they see in the room at the present moment, and then reflect upon it. The meaning that any particular interaction may have is co-constructed through conversations between family members and the therapists. This is how the treatment team began to shift Shelly's negative view of her daughter, not so much by directly challenging the view she held, but by drawing her attention to the link between her behavior and that of her daughter, and vice versa.

Two structured methods for developing a more relational and contextual perspective are Genograms and Relational Time-Lines. Although these methods sometimes are used as assessments, in ESFT they are used more as interventions with the goal of increasing awareness of the big picture of their family relationships. During the Genogram interview, as Shelly's history of sexual, emotional, and physical abuse was shared, the treatment team noticed Marilyn's sadness for her mother and they pointed it out to Shelly, with the goal of punctuating how much her daughter cares about her, and that when she lets herself be vulnerable, it pulls her daughter towards her. Shelly initially rejected the team's comments until Marilyn validated their observation. The final step in setting the stage for change is gaining the consent of everyone to a relational plan of action. This involves highlighting the team's observation of the family structure and the core negative interactional cycle, having family members reflect on and discuss the team's observations, and then refining this hypothesis until it resonates with everyone and becomes a shared narrative about the process.

After highlighting many times the way Marilyn would escalate and de-escalate based on whether she was emotionally available to her or not, Shelly began to soften her perspective. After much

discussion, the team and the family eventually settled on the following working systemic hypothesis: "The more that Shelly is distant and unavailable to her daughter, and the more she tells her she is possessed, the more Marilyn is alone and defenseless, vulnerable to negative influences inside her head and outside the home." Another component of this problem definition involved Allen. "And Shelly, when Allen sees that you are unavailable to Marilyn, he believes he needs to parent her … leaving him with the awful decision of whether to attend school or stay home and take care of you and Marilyn." This resonated with Shelly and it created a clear role for her in the change process. This frame also validated Marilyn and Allen's experience and validated their desire to have their mother step more fully into a parenting role.

Applying ESFT: Working the Four Cornerstones

Once everyone has signed onto a clear systemic, psychologically-informed definition of the problem, ESFT therapists collaboratively develop a plan with the family that is organized around the four cornerstones of treatment. Therapists then devote their focus to supporting family members in taking the action steps to which they have committed. It is at this point that the sixth core mechanism of change is most prominent.

In ESFT, all four cornerstones are worked on simultaneously, meeting with the family as a whole, as well as with different subsystems, depending on the action step being addressed. In this case, the team occasionally met with each family member alone, initially to join and learn more about them, then to prepare them for focused conversations in sessions involving mother-daughter, mother-son, co-parent, and the family as a whole. Regardless of the specific content the family may bring up in sessions, therapists attend to opportunities within each of the four treatment domains for family members to use their strengths and resources to take the actions they have agreed to in the plan.

Strengthening the Caregivers' Emotional Support of the Child

The focus of the work in this arena is the caregiver-child relationship, helping it to become a resource for the child, particularly in the child's efforts to self-calm and regulate behavior. Here, therapists focus on both the caregivers' emotional availability to the child and the child's receptivity to the caregivers when they are trying to support them. Outcomes include: 1) caregivers are showing more curiosity, empathy, and acceptance of the child, 2) caregivers are more often seeing their children's misbehavior as a sign of potential distress, not an effort to defy or irritate them, and 3) children are learning to be less provocative when initially met with a disappointing parental response. To achieve these outcomes, therapists help both caregivers and their children learn to pause when they are agitated and then to regulate themselves before responding. The best evidence that children are

beginning to see their parents as a real source of emotional support is when they begin going to them for comforting and problem-solving. This new relationship pattern greatly reduces the child's risk for a wide range of negative outcomes because caregivers are working to soothe and de-escalate their children.

In the treatment of Marilyn's family, the initial step was to cultivate a less hostile, rejecting relationship between mother and daughter. The therapists saw this a longer-term goal, not possible at this juncture. Just getting this mother and daughter into the same room together and keeping them there for more than 10 minutes, took the entire first 30 days of treatment. The therapists were patient because they understood that Marilyn was as much of a trigger for Shelly's overwhelming anxiety and sense of danger as Shelly was for Marilyn. The team acted as an accepting, calm emotional anchor for Shelly and Marilyn, setting their first action step small – just being in the same room together with the team while talking about non-emotionally charged topics for 20 minutes.

Once Shelly and Marilyn achieved this goal, the team and family set another action step – successfully talking about one sensitive, emotionally upsetting topic without either of them storming out of the room or yelling. In ESFT, all conversations in treatment sessions are seen as opportunities to help families expand their tolerable range of emotional intensity, to communicate past the point at which they usually stop talking, and to resist customary negative coping patterns such as avoidance and attack. When therapists set up and facilitate these conversations between family members with this intent they are using a technique known as *enactments*. The majority of conjoint family sessions in ESFT involve repeated enactments. It is this vehicle that creates the condition for family members to practice new, more functional patterns of relating.

An example of how this works can be seen in the following excerpt from one such conversation between Marilyn and Shelly, which was triggered by Marilyn bringing up how she does not feel her mother knows much about her. Shelly reacted to the introduction of this topic by distancing from Marilyn and making an attempt to shut down the conversation. The therapists intervened quickly to remind the family of the negative interactional cycle that they have both agreed they want to change, while refocusing them on the topic at hand. You will note the therapists do no coaching or teaching in this exchange, but instead facilitate and remind them of previous successes. The goal is to successfully complete an emotionally charged conversation because it is this repeated experience that is assumed to build competency and more stable relationships.

Shelly (softly, looking away from her daughter*): "I've lived on this earth a lot longer than you and I have experienced a lot of things …"* (Marilyn interrupts)

Marilyn (sharply, but with incredulous laughter): *"And I've experienced a lot of things too woman. You have no fucking idea!"*

Shelly begins to shut down, looking like she was about to retreat to her bedroom.

Therapist (calmly, but firmly): *"This is what we talked about last time Shelly, when the exact same thing happened. And I know how much you hate the cursing. But remember how you discovered that you can easily trigger Marilyn when it sounds like you are dismissing or judging her. Is it possible that is what is happening right now?"*

Marilyn (more calmly): *"I don't like it when you make assumptions about me mom. You make assumptions about me and then you close your ears and don't listen to anything I might try to tell you. It gets me fuming."*

Shelly begins shaking her head and then puts her head in her hands looking down, which escalates Marilyn again, who begins cursing and getting loud, criticizing her mother's religious beliefs. The therapist interrupts Marilyn by beginning to talk directly to Shelly.

Therapist (calmly, with curiosity): *What's happening for you Shelly when she's screaming? I'm betting it's pretty hard to listen, even if it is because she's hurt.*

Shelly feels the therapist's support but comes back vigorously defending her religious beliefs, further escalating Marilyn, and requiring the therapist to interpret and remind Shelly of her successes in other sessions avoiding the current negative cycle.

Therapist (softly with persistence, while Shelly continues to pontificate about religion*): "Shelly …. Shelly … Shelly …. (Shelly pauses and looks at the therapist.) What do you think Marilyn wants from you at this moment? You did an excellent job last week when the exact same thing happened. A subject came up, one you didn't want to talk about, and you started to shut down, Marilyn was insistent on pursuing the issue. But then you were able to shift and become softer with her and you had a very productive conversation, a different experience for both of you. Try to give her what she needs at this moment so you guys can go there again. I know you know what that is … she just wants you to listen to what she thinks, you don't have to agree with it."*

Shelly (looking directly at Marilyn, voice a little stronger, more present): *Ok, we can talk about your beliefs, if that's what you think is important. I want to know, just don't curse."*

Although the therapists needed to interrupt and redirect many times when Marilyn and Shelly would become reactive, they maintained their role as *keepers of the conversation*, remaining neutral with respect to content. Marilyn tearfully explained to her mother the pain caused by her accusations that she is a demon possessed and her threats to take her to an exorcist. Shelly opened herself up

enough to hear Marilyn describing how hard she tries to be a good daughter and believes in God just as much as her mother, but needs her help. The conversation became pivotal in softening the mother daughter-relationship. In the eight months this family was in treatment, over 25 similarly intense conversations about many different emotionally laden topics were facilitated by the therapists, including Marilyn's relationship with her father and her brother, her drug use, a molestation that had occurred as a preschooler, and the impact of Shelly's mental health on her.

Equally important were the sessions with Shelly and Allen. Although he was not the target of as much hostility and rejection, he received little emotional support from his mother. Given his protective role with Shelly, Allen needed much more support and reassurance from the therapists than Marilyn to talk about his distress and needs with Shelly. As long as Shelly maintained her belief that Allen was the "good child," she was unlikely to become more curious about his suffering, which was significant.

Marilyn's mother, Shelly, has PTSD but has never sought counseling of any kind. It is this history that normally accounts for caregivers in fragile families to present with depression, emotional reactivity, and many times, lack of empathy for their children. It did not occur to Shelly that the way she felt might be a treatable mental illness because she had felt this way her entire life – it was normal. Further into treatment, once Marilyn and the family had stabilized, the team provided Shelly with psychoeducation about the link between her experiences, trauma, and her current reactions to Marilyn and Allen. By the end of family treatment, they were able to evoke more concern for her own emotional health and get her linked to an outpatient therapist. This is an important part of intervening in this treatment domain, when it operates as a barrier to a caregiver providing emotional support to his or her children.

Strengthen the Co-Caregiver Alliance

The focus of the work in this arena is to create support for stable caregiving within the family and reduce the leaking of parental conflict and negativity across generational lines. ESFT therapists have four general goals when addressing this treatment domain, which include: 1) ensure all family members involved in caregiving are engaged in the treatment, 2) ensure each caregiver is interacting with the children so they have real data to draw upon when discussing them, 3) encourage the sharing of all information with one another that is relevant to daily parenting, and 4) work to help caregivers set boundaries, containing their conflicts to the caregiving subsystem and not involving the children in them.

In Marilyn's family, the first goal was accomplished early in the treatment. The team next addressed the distance between Larry and his children. The emotional distance between Shelly and Larry was similar to that between Larry and each of his children. The treatment team encouraged Larry

to check-in more frequently with his children and they encouraged his children to reach out more to him. When one caregiver has little involvement with the children this places even more stress on the caregiver who is left to raise the children, which can be overwhelming. As Larry and the children had more contact, Shelly relaxed a little and felt less alone. Shelly became more willing to meet with Larry (via phone) and the treatment team.

The next step in strengthening the co-caregiving relationship was to have conjoint sessions with Shelly and Larry, where the treatment team directly addressed the negative patterns they fall into when interacting about the children. When they were living together, Shelly was highly reactive, negatively interpreting all of Larry's comments about their messy house and the amount of time she spent in bed. She would then shut down and stop speaking to him for weeks at a time. Even though it has been seven years since they have lived together, they were each still easily triggered into the old pattern. The treatment team urged Shelly to work through her frustration with Larry when he said something offensive and to refrain from shutting down. They worked with Larry to help him have more empathy for Shelly and to be less critical. Before treatment ended and after, Shelly was reaching out to Larry more frequently for support with Marilyn and had begun to share more information with him.

Strengthen the Caregivers' Leadership Role in the Family

The focus of treatment in this domain is to build more consistent, predictable structure in the home for everyone, particularly the children. Therapists know they have been successful in strengthening the caregivers' leadership or executive role in the home when caregivers have established a few reasonable daily routines and household rules, monitor follow-through with them, and provide reasonable consequences when necessary. The caregivers' consistency in maintaining such a structure is the key outcome because this equates with stability. To accomplish this, therapists need to help caregivers shift their mindsets from reactive, mood based parenting to one that is more intentional and grounded in what their children need. Basic parenting education is another important component of intervention in this treatment domain.

The treatment team saw, as a strength, that Shelly was able to establish routines for herself, although they all revolved around church and religious practices. There was no structure for managing the household or the children. When the treatment team initially came to the home, they were overwhelmed by the amount of trash, dirty dishes, clutter, etc. around the house. There were no regular mealtimes or bedtimes. The house itself was in such disrepair that the team had safety concerns. Given the chaos in the home and real safety issues, the treatment team decided that helping Shelly to make a commitment to reclaiming the house for her family was a priority. This meant making some

repairs and evicting two boarders renting the living room space. Although it took a while for Shelly to build the courage, she eventually evicted the renters, which became an important victory for her and her children. The treatment team helped Shelly build on this success and referred to it often as they discussed small ways she could bring more leadership to the home. The other major leadership role she followed through on was monitoring Marilyn's medication. This was an essential component of Marilyn's recovery because Marilyn often forgot and this would have a direct effect on her daily functioning.

The treatment team had frank talks with Shelly about how much Marilyn required structure to function. This was a challenge to Shelly's belief that Marilyn should be self-sufficient. The team used Marilyn's Time-Line, from age eight to 17, to show how Marilyn's functioning in school and at home was directly related to the availability of another adult in overseeing her day-to-day activities. For example, she did best in the classroom when she had wrap-around services and she did better in the home when her father was still present or when Shelly was functioning better as a parent. They also pointed out how Marilyn has deteriorated when Shelly was depressed and not functioning in a caregiving role.

The team made a clear link between consistent structure, ongoing parental attention and nurturing, and Marilyn's ability to make a full recovery from mental illness. Although Shelly was making significant changes, the team also was aware there was a possibility her own recovery from severe mental illness may not proceed quickly enough for her to parent at the level Marilyn would require at this moment in time. Marilyn remained vulnerable, having had a significant psychotic break only six months earlier. As part of preparing for discharge and thinking about aftercare, the team brought this dilemma up with Shelly.

The therapists' objective was to empower Shelly to make a responsible decision about whether Shelly should live in a therapeutic foster home. They reviewed how she would know when this became necessary and encouraged it to be a collaborative decision made with Marilyn. The team made it clear that not having a fully functioning parent in the home was not an option for Marilyn. Previously, Shelly had blocked all such discussions. This time, she was able to separate her guilt and fear about losing control from listening to Marilyn's needs. This was pivotal for Marilyn who now knew that she could request to leave her mother's home if necessary without feeling tremendous fear that her mother would never speak to her again.

Build Support for the Caregivers and the Child in the Extended Family and Community

The fourth cornerstone of ESFT treatment is often the most challenging because the family may be cut-off or alienated from many relationships with extended family, and they may distrust their

neighbors and organized community organizations. Yet, this component of the treatment is critical for sustaining changes the family has made during a course of treatment. The goals are specific when working in this arena. One, the caregivers are working toward establishing at least one adult relationship outside the nuclear family who supports their efforts to be a better parent. Two, the child is developing a relationship with another adult outside the nuclear family, whether in the extended family, school, or community who they trust to provide guidance and support when their parents are not available. Belonging to a group of pro-social peers is a protective factor for adolescents in fragile families.

One of the major community-based interventions in the treatment of Marilyn's family involved Shelly's pastor and members of her church. Midway into their eight months with the family, the team asked Shelly for permission to speak with her pastor and invite him to a session. He came along with a deacon. The team told them that they respected how Shelly's faith was an important asset for the family. At the same time, they spoke frankly about how fragile Marilyn's mental health is and how much she needs her mother to believe in her ability to recover. They told the pastor and the deacon that talk of demon possession pushes her more into mental illness and hopelessness. The pastor and deacon were receptive to the team and seemed appreciative to have a coherent explanation about what was going on with Marilyn in the context of her family. They did not know Marilyn and had only heard frightening stories from Shelly. The pastor and deacon made an agreement with Shelly that they would support her relationship with her daughter by reminding her to have faith, and invited her to call them for support when she feels like giving up and thinking about demons.

Clinical Outcomes

Fragile families can become less fragile and more functional with targeted eco-systemic interventions. At the end of eight months of intensive, in-home family-based treatment using ESFT, Marilyn's mental health was more stable, there were no safety concerns, and she had returned to school. This was a good child-focused outcome given the state she was in when treatment began. ESFT therapists would not be satisfied with this outcome alone, however, if they could not also say with confidence that the family was more stable and functional as a result of the treatment. ESFT therapists ask themselves, can the changes we see in this child be supported and sustained by her environment? One of the main points of this chapter was to demonstrate that children with emotional problems who live in fragile families are unlikely to remain success stories when their families do not become more stable and supportive. When families are not involved in treatment and do not change, children with SED often become trapped in a cycle of failure and under-functioning, regardless of momentary successes in the various treatments they are likely to receive over their life course.

Here, Marilyn stands a reasonably good chance of remaining stable and returning to a more positive developmental pathway because there were significant changes in the way her family organizes their relationships. For example, Larry, her father continued to stay involved by phone with Marilyn and Allen. This new relationship pattern continued without the therapists because they each got something important out of their interactions with one another, and Shelly supported it. Although Marilyn never felt she could turn to her mother for deep emotional support, they developed a more positive relationship. Shelly's hostility subsided. She stopped saying her daughter was possessed because she no longer thought this. As Shelly developed more understanding of how her history of trauma and PTSD had compromised her ability to be the person she wanted, she became more empathic and open to getting to know her daughter.

About three months after the treatment ended, Marilyn felt her mental health slipping again as she confronted old challenges of dealing with unkind peers and trying to catch up on academic work she fell behind on while out of school. This time Shelly noticed Marilyn's distress, but acknowledged she was not yet able to provide what she needed to get through it. Together, Shelly, in collaboration with Larry and Marilyn, decided that short-term placement in a therapeutic foster home would be beneficial, which they were able to arrange. Marilyn remained in communication with her parents throughout her six months there.

Marilyn still suffers from Bipolar illness, and must remain vigilant about managing it, she no longer feels unstable, does not see herself as hopelessly and chronically mentally ill like before. Marilyn has had no further inpatient hospitalizations as of the last follow up one-year post treatment. A successful treatment does not necessarily mean everything is working well. Post-treatment, Marilyn still faces many day-to-day stressors and there remains much pain about her family life, but she is slowly re-entering the world of peers and work. Unlike many of her peers with similar conditions living in fragile families, Marilyn has not become one of the statistics of failure among children with SED mentioned earlier in the chapter, nor has Allen.

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