Eco-Systemic Structural Family Therapy:
A quick reference guide For Providers

ESFT is an eight-month in-home, intensive family treatment approach, originally developed in 1988 through a collaboration between Philadelphia Child Guidance Center and the Commonwealth of Pennsylvania. In addition to being grounded in systems theory, the approach is trauma-informed and attachment-focused.

Who is most likely to benefit from esft?

ESFT has been specifically designed to treat **children and adolescents up to age 21, with serious emotional disturbance who live in multi-stressed families.** Youth treated with this model have typically received multiple previous behavioral health services with limited success and are at risk of out-of-home care. In addition, both children and their caregivers often have a history of Complex Developmental Trauma. The model directly addresses the impacts of this history on current family organization and functioning. Although ESFT is not a specific treatment for single incident trauma and PTSD, it is compatible with and complements evidence-based treatments such as TF-CBT.

Children and adolescents treated with ESFT have serious difficulty regulating emotions and behavior and tend to carry multiple diagnoses. The most common presenting problems include oppositional defiance, aggression, problems with impulse control, ADHD, mood lability, depression (with suicidality), and anxiety. ESFT has also been successfully applied to families in which the identified child is on the Autism Spectrum (mild to moderate impairment) or has other developmental disabilities. However, the primary focus must be on the child's emotional/behavioral problems and/or family functioning, not the developmental disability itself.

are there any eXclusionary criteria?

Since most interventions flow through caregivers, **ESFT is not appropriate when there is no caregiver who is willing and able to commit** to ongoing involvement in the treatment. There is no requirement, however, that the child be living with their caregivers. For example, this model has been successfully applied to children in foster care when both the foster family and the biological parent are willing and able to participate in the treatment, and the plan is reunification.

ESFT is the appropriate service when the adolescent is engaged in mild to moderate anti-social behavior and/or is abusing substances, such as alcohol and marijuana, when the child's social-emotional problems are primary. ESFT may **not be the best fit for adolescents, however, when their primary issues involve more serious crime/delinquency or substance abuse**.

What creates and maintains chronic sed symptoms?

ESFT assumes that chronic SED symptoms are created and maintained by a **hyper-arousing, under-supportive relational environment.** This environment is driven by 1) underdeveloped emotional regulation (caregivers and child), 2) problematic parent-child attachments, 3) weak executive structure, and 4) inadequate support for the caregivers.

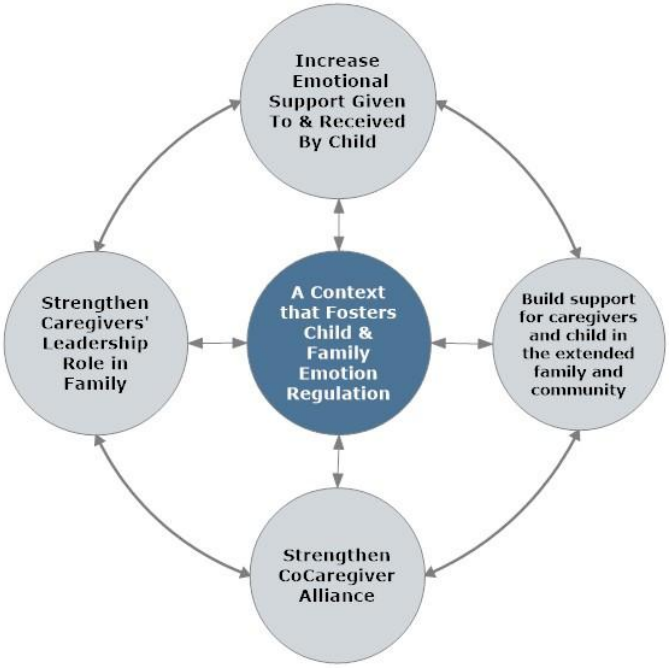
What are the goals (expected outcomes) of ESFT treatment?

Primary Goals: Child-Focused

1. Emotional/behavioral symptoms and safety concerns are reduced
2. Child is able to participate more fully in home, school and the community
3. Reduced risk for out-of-home-placement. Caregivers believe they can parent the child in home

Mediating Goals: Family-Focused

4. Caregivers better able to work together to establish/maintain reasonable household rules/routines
5. Caregivers able to be more emotionally available to child as a consistent source of support
6. Family better able to de-escalate conflict and use problem solving skills when tension is high



What is the focus of ESFT treatment?

ESFT therapists develop one overarching child-focused goal which generally focuses on how the "recovered" child will be functioning in the presence of known triggers or stressors. Specific interventions are organized around **the four drivers of treatment** (see figure). These are components of family structure that are critical to the child's recovery, i.e. his/her ability to achieve the outcome described in the overarching goal. During treatment planning, ESFT therapists collaborate with families to develop specific "action steps" in each of these four components of family functioning, communicating to all family members that their success is dependent on everyone doing their part, as a team.

How is ESFT treatment delivered?

TEAM Delivered: In PA, 60% of all services are delivered by both members of the treatment team. Outside PA, in programs where team members each work separately with the family, it's best if each team member has a clearly defined role with respect to the specific component of ESFT treatment he or she will be responsible. Regardless of how roles are divided, it is important that **team members regularly overlap in the home** so that families experience the team working as a team.

Service Intensity: Intensity is achieved in three ways. One**, therapists are in the home multiple times each week (2-3), totaling around 4-6 hours.** Intensity is also achieved by ensuring that **each session is driven by a "laser" focus on one overarching treatment goal and the specific action steps** each family member has agreed to take within each of the four treatment domains. Intensity is also achieved when **team members follow up on each other's discussions with family members every session**.

Subsystem Work: In ESFT, **each family subsystem is worked with separately to help create more functional subsystems and build appropriate boundaries around each subsystem**. For example, when therapists meet for longer sessions (2 hours), he or she may meet with the parents for 45 minutes to focus on their concerns about the child, help them work together more effectively, or prepare them for a conversation that they want to have with their child. The therapist might then meet with the child separately for 30 minutes to work on his/her action steps or to prepare him/her for a difficult conversation with parents. The last segment of this extended session may be a conjoint family session, where the therapist facilitates a conversation or problem-solving dialogue about the issue everyone has prepped for. When therapists have shorter home visit sessions, each session may be confined to only one subsystem at a time.

What are the Mechanisms of Change in esft (Markers of treatment fidelity)?

In ESFT, there are six conditions that when present, are assumed to account for positive and meaningful change. When measuring the extent to which a team is delivering the model as intended (treatment fidelity), supervisors review the teams' case conceptualizations, treatment plans, session progress notes and case presentations for the presence of these six conditions in the treatment being delivered. A caregiver version of treatment fidelity provides a consumer perspective on whether the family experiences the presence of these six conditions in the services they are receiving. A team is fully implementing the ESFT model when they are working to establish the following six treatment conditions:

- *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.*

What is the research evidence of effectiveness?

ESFT is considered a **Promising Practice.** While the model has not yet been subjected to a randomized controlled study, ESFT has 1) a clearly identified theory of change, 2) a treatment manual that specifies practice protocols, 3) general acceptance among practitioners and government regulatory bodies that it is helpful and appropriate for use with children and their caregivers, and 4) a method for demonstrating adherence to model fidelity.

There is an enormous amount of practice-based evidence suggesting that ESFT is a highly effective practice. The largest scale implementation of ESFT has been in Pennsylvania, where it informs Pennsylvania's Family Based Mental Health Programs. There are currently over 150 intensive, in-home programs using ESFT operating in all 67 counties of the commonwealth, serving several thousand children and their families each year.

The earliest state-wide pre-post outcomes study of ESFT comprised 1,968 families from 39 different PA FBMHS programs between 1988 and 1995 (Lindblad-Goldberg et al). The results demonstrated that ESFT reduces 1) presenting symptomology and that positive changes maintained one-year post discharge and 2) the use of more restrictive forms of mental health care, which is the mandate for the PA FBMHS program. Over the last decade, some of the larger behavioral health agencies with FBMHS have been producing annual reports of standardized pre-post and follow-up outcome data for children and families receiving ESFT. One of the largest treats over 500 – 600 children and families each year using the ESFT model. Their findings match those of the large-scale study. For example, these outcome studies show that six months' post-treatment 83-85% of children treated were 1) still living with their caregivers in their own homes, 2) attending school and passing, and 3) participating in lower levels of care.

Selected References

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