2022

Structural Family Therapy for Autism Spectrum Disorder: A Single Case Experiment

Anthony George Pennant Jr.

STRUCTURAL FAMILY THERAPY FOR AUTISM SPECTRUM DISORDER: A SINGLE CASE EXPERIMENT

A dissertation

Presented to the Faculty of
Antioch University New England

In partial fulfillment for the degree of
DOCTOR OF PHILOSOPHY

by

Anthony G. Pennant Jr

ORCID Scholar No. 0000-0003-3181-9716

August 2022

STRUCTURAL FAMILY THERAPY FOR AUTISM SPECTRUM DISORDER:
A SINGLE CASE EXPERIMENT

This dissertation, by Anthony Pennant, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of
Antioch University New England
in partial fulfillment of requirements for the degree of

DOCTOR OF PHILOSOPHY

Dissertation Committee:

Kevin Lyness, Ph.D., Chairperson

Denzel Jones, Ph.D.

Bryson Greaves, Ph.D.

Abstract

STRUCTURAL FAMILY THERAPY FOR AUTISM SPECTRUM DISORDER:

A SINGLE CASE EXPERIMENT

Anthony Pennant

Antioch University New England

Keene, NH

This research study is an exploratory single case experiment which was conceptualized through the concept of change as outlined in structural family therapy (SFT). This family reported increases in their levels of cohesion, flexibility, and satisfaction with their relationships. The family reported decreases in the levels of disengagement, rigidity, chaos, and communication. Lastly, levels of anxiety increased over time and were generally rated divergently by parents and the child with autism spectrum disorder. Given the outcome of the study, SFT shows promise in being an appropriate clinical model in providing family-based therapy for families who have a child(ren) with autism spectrum disorder. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: Autism spectrum disorder, family therapy, SFT, family-based anxiety.

Acknowledgements

There are many individuals that have lent their energy and support that have enabled me to be where I am today. My ancestors, those who have come before me, are some of the very reason why I have been able to complete this awesome project and academic accomplishment. I am thankful for what you have given, sacrificed and envisioned. I want to appreciate my family for their warmth and encouragement. I want to also thank my siblings for texting with me when I could not sleep or when I needed distraction. To the family that I write about in this dissertation, THANK YOU. Your willingness to help shape the landscape on how future families who have children on the autism spectrum receive treatment is noble and I hope the good fortune in your life is multiplied one thousand-fold. To Zach Lopez and Madison Parks, you two are fantastic structural family therapist. The field is ready for you to move it forward. I owe you both immensely for your hard work and dedication to this project. To my dissertation committee, specifically Dr. Kevin Lyness, I appreciate your support and encouragement. Your insight and knowledge helped me be a better clinician and scientist. To Ashlyn and Cyndi, you are up next!

Lastly to Courtney, you entered my life at such a precarious time, but what you offered helped carry me over the finish line. You are an extremely special individual who is so loving and kind. I am so blessed and fortunate to call you, my partner.

Table of Contents

List of Figures

CHAPTER I: INTRODUCTION

Autism Spectrum Disorder (ASD) is a complex and systemic diagnosis. Specifically, it is a developmental disability with variability in intensity of behaviors, impact on communication, social skill deficits, and restricted interests and repetitive behaviors. According to the Center for Disease Control (CDC, 2020), approximately 1 in 59 children were projected to receive the diagnosis in 2018. ASD affects approximately 1% of the population of the United States, and often a diagnosis is not made by professionals until late adolescence or early adulthood due to the variation in individuals' behaviors or clinical presentation (Govind, 2018). ASD affects various domains of a person's life, often causing distress and complications across their lifespan.

A hallmark of ASD symptomology is the impact on social communication and social cues. Individuals with ASD often have difficulty in expressing their emotions and conveying their internal world to others around them. Along with the difficulty in understanding social rules of engagement, individuals isolate themselves, creating inclusive yet separate worlds (Nealy et al., 2012). Children who struggle with social communication and the lack of ability to read social cues have extreme issues in school and often will be unable to demonstrate their bond with their families (Kelly et al., 2008). In addition, children with ASD engage in restricted interests, often choosing to show attention to one or two hobbies but contain deep and heavily involved knowledge about said hobbies. The knowledge of these interests or hobbies often rivals the knowledge of experts in the chosen area (Kelly et al., 2008).

Children with ASD are subject to comorbidity with various mental health diagnoses that affect their behavior. Depressive symptoms often occur in children with ASD, as they may struggle with making friends, communicating with their siblings, parents, and other family members, and with thoughts about their diagnosis adding to their perceived differences from society. While depression is an issue that affects children with ASD, the most common co-occurring diagnosis is anxiety (White et al., 2009). Children who

have ASD have elevated rates of anxiety when compared to both typical developing peers and children referred to mental or medical providers for clinical treatment of anxiety (van Steensel & Heeman, 2017). A typical approach to address these comorbid issues is applied behavioral analysis (ABA; Harris & Delmolino, 2002) for behaviors that impair daily living and individual therapy, usually in the form of cognitive behavioral therapy (CBT; Harris & Delmolino, 2002) for anxiety. Neither of these approaches include the family.

Parents in families are the initial advocates of mental health and wellness for their children (Lopez et al., 2018). They are the first individuals who will see their child(ren) achieving milestones of development, monitor and train their children for acceptable behavior, and assist them in regulating and expressing their emotions. When their children do not display typical behaviors, emotions, or milestones, parents will solicit assistance from the medical community for explanations. Parents who have children with ASD have several barriers to confront and overcome when piloting both the behavioral presentations of their child but also in navigating behavioral health services (Hall et al., 2017). In addition to these issues, parents experience several issues related to the ASD diagnosis of their children, including parental stress, parental burden, loss and grief, partner/spousal strife, and partner/spousal anxiety (Kelly et al., 2008). Out of these issues, stress related to parenting children with ASD has not been fully investigated (Moh & Magiati, 2012). Parental stress is described as occurring when the needs of the family, which includes the care and wellness of the children, outweigh the available capacity of the parents (Hsiao, 2018). Parental stress manifests when the child's behavior is unceasing, unmitigated, and unresponsive to treatment, and is exacerbated by other social and emotional issues in the family (Miranda et al., 2019). This stress can impact parental well-being in a variety of ways, including parental burden (Picardi et al., 2018), experiencing and amplifying loss and grief (O'Brien, 2007), inter-partner strife, and impacts on parents' social and community networks (Ingersoll & Hambrick, 2011).

Couple/marriage and family therapists (C/MFT) are behavioral health practitioners who believe problems manifest between individuals and are not solely in individual pathology. Through their training, C/MFTs understand that issues in relationships are the underpinning to problematic patterns in families, which keep negative and problematic cycles in place. It is with these problematic patterns and the recursive communication that C/MFTs involve themselves. Raising a child is a large undertaking for parents. They must utilize several resources to support the development of their child, who, when they are older, will be well prepared in navigating the world. Parents who raise a child with special needs such as ASD face unique challenges, such as impacts to family functioning, demands of the child, navigating and advocating with service providers, and isolation of their experiences and emotions about said experiences. Given the literature on children with ASD and their caregivers, it is imperative for researchers to understand if there is a link between the anxiety of children with ASD, parents' anxiety levels in raising children with ASD, and the protective and/or predictive factors of family cohesion and family adaptability. The symptomology of ASD and the diagnosis itself have a systemic impact on not only the child's functioning, but also the functioning of the caregivers and siblings in that family system. Throughout the existing research, many domains of mental health impairment have been investigated; what remains to be examined is the link between parental anxiety, ASD, and family functioning/dynamics.

As this is a research study that seeks to explain the relationship between ASD, anxiety, and family structure, the choice to use structural family therapy (SFT; Minuchin et al., 2021) as a treatment model is highly suitable. SFT is a systemically informed model that has been in use for many years (Colapinto, 2019). The focus of the model states that problems exist within families, as their boundaries and hierarchies are rigid and do not allow for adaptability in organization and structure. In addition, the model also states the chaotic and disorganized family structure plays a supporting role in problematic behaviors impacting family functioning. This study will provide novel protocols in treating children with ASD alongside their family members to address various mental health issues, as the treatment as usual for an ASD diagnosis is

ABA therapy individually. A family will receive SFT in an intensive manner (twice per week for 90 minutes) for ten sessions. Each session, the therapist met with the entire family for 45 minutes, and the remaining 45 minutes were allocated to working with the parents. Assessments/measures were obtained three times (prior to treatment, midpoint at session 4/5 and one week after the tenth session) over the course of the ten sessions. The measures were completed as a family, and one answer was given for the family. The data was analyzed via visual analysis, which is the preferred method when using a Single Case Experiment (SCE) as scientific method design. This study investigates the following:

1. Is SFT an appropriate therapeutic model to address rigidity of family systems with children who have ASD?
2. Is SFT an appropriate therapeutic model to alleviate family based (parent + child) anxiety with a family who has a child with ASD?
3. Will SFT address and adjust family cohesion and family adaptability allowing for family-based anxiety to decrease?
4. Can SFT increase family cohesion and family adaptability?

CHAPTER II: LITERATURE REVIEW

ASD has begun to enter the realm of public health as a diagnosis that affects millions of families each year. According to the CDC (2020), approximately 1 in 59 children will receive the diagnosis in 2018. Other reports have stated that "ASDs affect at least 1% of the population and often diagnosis is not made until late adolescence and early adulthood due to the diversity in the ASD symptom profile and clinical presentation" (Govind, 2018, p. 908). ASDs affect individuals by compromising their ability to understand social cues, they may involve some intellectual and developmental delays, and they often are comorbid with other mental health issues. Govind (2018) also states, "Difficulties with learning and psychiatric comorbidities such as anxiety and depression are frequently associated with ASDs. These comorbidities further complicate and compound difficulties across multiple domains of functioning and intensify reliance on family members" (p. 908). The pathway to gaining a concrete diagnosis for autism spectrum disorder is long and arduous. Many times, families are told to wait out signs of the delay of milestones, as each individual child may be behind in development; this often delays the support the family needs. In other families, children have significant displays of deficit in development, and a diagnosis can be made sooner than usual. Families raising children who have ASD face unique and challenging circumstances that create conditions for mental health issues and relational problems such as depression, anxiety, isolation, marital discord, divorce, financial problems, and sibling neglect (Hartley et al., 2011). When these various issues have room to fester, it ultimately negatively affects the structure and functioning of the family, which in turn creates more dysfunction for the entire family (Hsaio, 2018; Miranda et al., 2019; Myers et al., 2009; Norton & Drew, 1994).

Family therapy is a specialized field of psychotherapy that focuses on interceding between the relationship and aims to support open and clear communication (Spain et al., 2017). This form a therapy is well equipped to deal with the obvious gap of treatment protocol present in treating families with a child who has ASD as the focus of relationships, and the emotions between others is the basis of intervention.

Family relationships impacted by the diagnosis of ASD—such as siblings of a child with ASD, parents, or grandparents of a child with ASD, and the relationships the child with ASD has with others—are all areas that need support across the lifecycle pre- and post-diagnosis (Ramisch, 2011). There are many models that are present within family therapy, offering similar abilities to be able to address these needs; however, SFT holds the most promise, as I believe it is the easiest model that can be executed efficiently by the clinician and offers strong, lasting skills that can be easily applied to the future developmental needs of the child with ASD as well as the family. This enhancement of treatment with families who have a child with ASD would invite parents to process through their own emotions, diversify caregiver roles, or expand on the responsibility of the household alongside examining sibling dynamics and strengthening the executive subsystem of the family. In addition to this, family therapy invites the emotional wellness and regulation of the child with ASD to the forefront of treatment, encouraging balance and congruence between all relationships in the family. The general pathway to diagnosis for children overlooks the emotions, care, and well-being of the parents and often overlooks how some of the children process through their own emotions and assume they are not present nor integrated.

Lack of Clarity in Diagnosis

ASD is a developmental disability that currently has no clear biological marker and is evaluated and diagnosed through examining where there is a significant decrease and impact to a cluster of behavioral, emotional, and perhaps physical realms (O'Brien, 2007). Furthermore, while a diagnosis can be given to children in their younger years with high reliability and validity, many children do not receive their diagnosis until they are school age (Lord et al., 2006; Moh & Magiati, 2012). The delay of diagnosis of ASD within children of color is even more so pronounced, impacting children's and families' trajectories through their developing years (Lovelace et al., 2018; Sansosti et al., 2012). The longer that parents and children must wait for an official diagnosis from medical providers, the longer there is an endurance of

behaviors without proper intervention, which increases the level of emotional turmoil for the parents and the entire family (Crowe & Lyness, 2014).

Systemic Issues of Families with Children with ASD

ASD is a complex neurological diagnosis that is difficult to diagnose and treat, and it creates a lifelong impact on the individual and those they relate to. Systemic effects of autism are outside the scope of "training for behavior analysts, as caregivers are included in treatment exclusively to develop appropriate parenting skills such as instruction, modeling, practice, and feedback to decrease the undesired behavior" (Parker & Molteni, 2017, p. 135). Families that have children who have been diagnosed with autism spectrum disorder face a unique set of issues that often go under-addressed. One of the primary issues that is prevalent within these families is the elevation of the diagnosis or behaviors enshrined in the diagnosis to one of power over all individuals in the system. Family routines are often adjusted around easing transitions and behavioral/emotional reactions of those with ASD. Little flexibility allows for adjustment, and if differences in routine are needed, a great deal of physical and emotional work may be needed to accomplish this. Another issue is that of emotional connection and reciprocity of feelings between child and parent(s). A very small amount of time is devoted to the actual deepening of interpersonal relationships within the family system. "Research shows that the non-ASD sibling possesses more negative views about their ASD sibling when compared to sibling pairs containing a child with mental retardation and a typical development child. Children with an ASD sibling (McVicker, 2013) has also expressed only being able to talk with someone outside of the home about their sibling, feelings of loneliness and a desire to stay home, and feeling concerned about their siblings' future" (Smock-Jordan & Turns, 2016, p. 157). In addition, sibling issues often arise, namely in the competing of needs. Siblings of children with ASD often feel overlooked and dismissed, as their needs never fully rise to the same level of urgency of those with ASD. This presents the opportunity for jealously, emotional issues, and resentment to fester. In addition, the siblings often receive a lack of attention from their caregivers due to the needs of their siblings with ASD. Often, the

parents' journey is overlooked and under-validated and seen as being a part of the caregiving duties as it is comparative to raising/experiencing normative stress of raising typically developing children. Parents experience a great deal of shame, hurt, and guilt around raising their child without having the proper or necessary support to expand their roles, which are significantly different from raising a neurotypical child(ren) (Lovelace et al., 2018; Myers et al., 2009; O'Brien, 2007). Furthermore, given the inherent stress of role expansion without proper support, marital and relational stress is often left unchecked or untreated within the context of treatment (Zablotsky et al., 2013). The structure of families is variable, and according to systemic theories, flexibility in structure and clarity of roles lead to an adaptability that allows for lower levels of anxiety and the successful management of problems, including transitions through life stages (Colapinto, 2019; Minuchin et al., 2021). The flexibility in structure and clarity of roles can be seen across all constellations of families despite their culture, racial, and/or ethnic make-up (Lopez et al., 2018). Challenges arise when the family structure is misaligned in some form. SFT states that when the parental subsystem is unable to be aligned and boundaried off from the child(ren) subsystem, the hierarchy of decision-making inherent in the parental subsystem results in the parents being unable to execute their duties of safety and support for the family (Colapinto, 2019). Families with children who have unique needs or disabilities often have challenges due to the ever changing emotional, physical, and spiritual needs that imitate how dynamic their presenting problems are. "The literature on the adaption of families of children with disabilities repeatedly indicates that it is important for service providers to understand family belief systems, both in a general sense and with respect to each family as a unique entity" (King et al., 2009, p. 50). It is extremely important to note that at the foundational level, families are units and systems that have organization and that self-regulate. Before setting out to find out what is wrong with families, King et al. (2009) state that clinicians will need to examine and highlight where strengths may exist within the family. "The family's ability to ascribe positive meaning to life events is considered to be a factor that promotes their child's resilience" (King et al., 2009, p. 51). In addition, "Understanding family's beliefs is considered

to be an essential aspect of engaging parents in the therapy process" (King et al., 2009, p. 51). These are basic joining techniques that are essential for working with parents of children with ASD. To prescribe the correct or the most culturally attuned intervention, clinicians (including doctors) should spend time understanding the culture (Lovelace et al., 2018; Suite et al., 2007) of the family, and they should be interested in some of the perceived and overt strengths that are present. In addition, creating systemic treatment modalities that are modified to address the needs of families with children who have ASD allows the caregivers more room to be flexible with their roles and support for one another when these roles fail to meet necessary standards. This is extremely helpful to parents who repeatedly verbalize the lack of family support for treatment for ASD (Kiami & Goodgold, 2017). Likewise, it provides the family with concrete ways in which they can celebrate when their accommodations and boundary-making contribute to the growth and development of the child, as well as family cohesion on a macro-level.

History of Treatment of ASD in Children

The general process of children being diagnosed with autism spectrum disorder begins with caregivers acknowledging that their child may be exhibiting developmental delays in meeting milestones and/or other behavioral manifestations that can be seen as somewhat bizarre, reclusive, or lacking in interpersonal reciprocity (Lovelace et al., 2018; Pearson & Meadan, 2018; Sansosti et al., 2012). Parents then attend multiple medical appointments, beginning with their primary care physician and then working their way to solidify a diagnosis with a neurologist or pediatric neurologist. This assessment often entails a full-length interview with parents, gaining their insight and understanding about the behavior of their child, their social interactions, their developmental history, and other behavioral/social information. Once a diagnosis is confirmed, the customary mental health treatment involves assigning an applied behavioral analyst (ABA) to help address some of the behavioral issues that are inherent with the diagnosis of ASD. These include repetitive behaviors, mastering activities of daily living, transitioning from one task to another, and incorporating social skills practice with other children their age.

ABA therapy has been espoused as the evidenced-based model to treat ASD. ABA is founded on the behavioral analysis of an individual and rests on three pillars of intervention. Dillenburger and Keenan (2009) state these pillars are: “Philosophy of the science: behaviorism, Basic experimental research and Applied Research” (p. 193). “Behaviorism defines behavior as anything a person does. The key point of behaviorism is that what people do can be understood” (Dillenburger & Keenan, 2009, p. 193). This provides ABA therapists a basic unit in how to intervene and measure change. There is also a school of thought that believes (although thoroughly challenged [Blackledge & Hayes, 2001]) that behavior(s) encompass not just the physical actions we see, but emotions, cognitions, and feelings of individuals. “The philosophical basis of modern behavior analysis stems from the early work of Skinner (e.g., Skinner, 1938) and sits in stark contrast to the earlier methodological behaviorism, in which only publicly observable behavior was considered relevant to psychology” (Dillenburger & Keenan, 2009, p. 194). The second pillar that Dillenburger and Kennan (2009) describe is experimental research or the experimental analysis of an individual’s behavior. In the many years since Pavlov and Skinner’s experiments documenting reinforcement, punishment, and behaviors that came about due to these forces, the field of behaviorism has been able to establish a significant amount of research that has informed a great deal of interventions and our understanding of the human mind and body (Pandya, 2011). The last pillar is behavior analysis, which Dillenburger and Keenan (2009) describe as “the science in which tactics derived from the principles of behavior are applied systematically to improve socially significant behavior and experimentation is used to identify the variables responsible for behavior change” (Dillenburger & Keenan, 2009, p. 195).

Within the confines of ABA, there is one intervention that is central to the treatment of ASD, discrete trial instruction (DTI; Harris & Delmolino, 2002). DTI is derived from the assumption that behavior is learned and that the science and laws of learning theory can be applied systematically to the education of young children with autism. The goal of DTI is to present information to the child in a clear, concise, and consistent way because research shows that children with autism acquire information most

readily when it is presented in a structured format. DTI is characterized by a careful, deliberate, and specific organization of antecedent and consequent stimuli (Harris & Delmolino, 2002, p. 14).

In addition to ABA therapy, many behavioral therapists will engage programs such as Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH; Virues-Ortega et al., 2013). The TEACCH program (a) emphasizes a close working relationship between parents and practitioners, (b) adapts the intervention to the characteristics of the individual client, and (c) makes use of structured teaching experiences (Van Bourgondien & Schopler, 1996). The TEACCH specialist would use structured teaching procedures to facilitate the acquisition of the learning goals composing the individual's curriculum (Virues-Ortega et al., 2013, p. 941).

The TEACCH program seeks to inform, instruct, and codify specific learning goals for the child(ren) specifically in their environment. This program seeks to partner with the parents and empower them to teach their children how to grasp and adapt to the needed skills necessary for activities of daily living. For these goals to be achieved, the TEACCH model leans on three foundational understandings:

> "Three factors are reportedly essential in this connection: (a) organization of the physical environment in a way that is consistent with the needs of the child (e.g., minimizing possible distractions), (b) arrangement of activities in a predictable fashion (e.g., use of visual schedules of daily routines), and (c) organization of the materials and task to promote independence from adult directions/prompts (e.g. use visual materials if the student is more able to benefit from them)." (Virues-Ortega et al., 2013, p. 942)

Behavioral modification is the first line of treatment for children with ASD; however, medication management may be an appropriate intervention for individuals who do not respond well to behavioral management or who have biological imbalances that spur on other behaviors. Medication is often prescribed to treat or manage various symptoms that impede children's ability to function at home and/or in the school system.

ASDs are commonly associated with learning disability and high rates of psychiatric comorbidity, including anxiety disorders, depression, attention deficit hyperactivity disorder traits, and more general "emotional and behavioral problems. Comorbidities further compound difficulties across multiple domains of functioning and exacerbate reliance on family members as well as career stress and burden" (Spain et al., 2017, p. 3).

Several medications are usually prescribed for children with ASD depending on the presenting issues the parents are wanting to address. A few of them are as follows:

- Aripiprazole, also known as Abilify, is an antipsychotic, second-generation "atypical" drug that is prescribed to lessen physical impulsivity and physical aggression (Thorton, 2019).
- Clozapine is an antipsychotic drug that is used to decrease hallucinations and suicidal behaviors. It is also a mood stabilizer (Sinha, 2019).
- Haloperidol, also known as, Haldol, is a first-generation antipsychotic drug that assists in treating out-of-control movements and outbursts of sounds and words (Multum, 2019).
- Sertraline, also known as Zoloft, is used to treat a wide array of symptoms, including depression, OCD, anxiety, PTSD, and social anxiety (Entringer, 2019).
- Oxytocin. This hormone is responsible for the bonding that occurs between mother and child as it is released during birth. Affectionately known as the "love drug," it ensures that social interaction occurs. In recent drug trials, "Remarkably, daily intranasal oxytocin treatment over development improved later social engagement, suggesting that early exposure to oxytocin restructures neural circuits to permanently rescue social impairments in this ASD model" (Young & Barrett, 2015, p. 1).

While the number of drugs discussed in this portion of the review is short, there are many more that may be prescribed to children for a variety of reasons and symptomology resolution. It should also be noted that biochemistry plays a large role in dictating if medication will abate some of the symptoms that are

being treated, which can lead to large bouts of trial and error (to the large dismay of parents) before knowing if the medication is effective (Jobski et al., 2017).

Generally, this modality of support (ABA and medication management) is well received in the community, produces lasting results for the child(ren), and lessens the parental burden of caring for a child or children with special needs (Harris & Delmolino, 2002; Smith et al., 200). However, there appears to be a gap in how family functioning and/or parental grief is addressed when raising a child or children with needs that change (Kiami & Goodgold, 2017). Treatment tends to focus on how well the child(ren) can do but not on the expanding role and resources that are needed to maintain a healthy amount of family functioning or to reduce parental distress. As mentioned earlier, there are a wealth of interventions that are used in treating children with ASD; however, there is no official guideline in assessing and treating the caregivers (parents, grandparents) or siblings of families who have children with ASD (Sansosti et al., 2012).

Studies have found that parents of people with ASD can present with higher levels of stress, distress, fatigue, anxiety, and depression symptoms than those reported to parents of typically developing or other clinical populations. Additionally, research findings suggest that caretakers can experience concerns about their parental efficacy and coping, and that marital satisfaction can be affected. There has been some, albeit limited, research about siblings of individuals with ASD (Spain et al., 2017, p. 3).

It should also be considered that while parenting involves the continued evolution of roles, expectations, and duties, assessments may not currently be able to pick up presenting issues in parents. Shame, embarrassment, and other forces (religious or spiritual beliefs) may shut down the parents' ability to feel, connect, and express these feelings, and they may seek to find energy to consistently shift their roles as caregiver.

Currently, there are no clinical trials demonstrating the efficacy of family-based treatment for children with ASD and their families in a systemically and integrated fashion that highlights the well-being of the family as a whole. That is not surprising as stated by King et al. (2009):

> Little research has used the family as the unit of analysis, with the exception of studies by Trute and Hauch (1988), who had both parents complete "family level" measures, and Patterson and Garwick (1998), who employed conjoint family interviews to determine the worldviews of families. Typically, studies have focused on mothers' reports to identify changes or transformations in mothers' beliefs about the meaning of disability over time and mothers' construction of their identity as parents of children with special needs. (p. 51)

In addition, "Campbell (2003) pointed out that providing support and psychoeducation is necessary for family caregivers, but in order to reduce overall burden and improve emotional health, caregivers need intensive interventions that target problem-solving skills, provide future coping strategies, and promote efficacious feelings as a caregiver" (Ramisch, 2011, p. 305). Improving and addressing these issues will ensure that all members who have been previously overlooked and under-cared for in the treatment of ASD receive attention, and it will hopefully ensure more positive outcomes for these families.

Family Factors in ASD

Parental Stress

Parental stress can be defined as "parental perceptions of an imbalance between the demands of parenting and available resources" (Hsiao, 2018, p. 201). Parents who have children with special or unique needs based on genetic, physical, or emotional differences than typical children experience higher levels of parental stress than other parents who have children without these needs (Miranda et al., 2019). Parents of children who have ASD demonstrate a significantly higher level of stress in their parental roles (Kiami & Goodgold, 2017). The presence of parental stress within families of children who have ASD often leads to trouble in other areas of the parents' lives, such as in lower martial satisfaction, marital quality, and marital

adjustment (Hartley et al., 2011). According to the literature (e.g., Nealy et al., 2012; Sim et al., 2017), the stress of parenting a child with ASD clearly has an impact on the relationships and roles of the parent, and other areas, such as problem behaviors and its impact on the level of stress in the parent. While behaviors in children with ASD vary, there are several common behaviors (sleep hygiene, communication issues and patterns, future life planning, independence/dependence, and rigidity of schedules) that present challenges for the child and impact the level of stress in parents (Brockman et al., 2016; Nealy et al., 2012; Su et al., 2018).

Sleep Issues

Prolonged issues with sleep, such as insomnia and other disruptions to slumber, are prevalent with children who have ASD (Veatch et al., 2017). Struggles with sleep in children with ASD affect other individuals in their home and often the early rising, night awakening, insomnia, and other disturbances have negative ripple effects to others in the home, especially parents and primary caregivers (Ming et al., 2009). The presence of severe and long-lasting sleep hygiene issues has a direct correlation to higher levels of parental stress, as this becomes an area of concern where parents may find the available solutions (often nonexistent) far outweigh the resources that are available.

Communication

Children with ASD often have pervasive issues with communication that are compounded by the severity of their diagnosis and their ability to be verbal in communication or not. The level of impact to an individual's communication can be dramatic and noticeable or subtle and nuanced (Spain et al., 2017). Parents may find that communicating with their children who have ASD to be laborious or downright confusing. Often children will communicate excessively, obsessively, and in an in-depth degree about a certain topic well above their chronological or developmental age (Splinter Effect; Spain et al., 2017) while not possessing the ability to ask for basic things such as a beverage or a snack (Norton & Drew, 1994).

Based on the existing review of the literature, there is a clear connection between problematic communication issues native to an ASD diagnosis and parental stress.

Life Planning

Families in general plan for their children's lives in advance by arranging college funds, assistance with therapies, and other ancillary services that their child may need. Parents of children with ASD experience this same duty of planning, but the level of stress is higher due to variable needs of the child and the increased stress on finances and other resources (Nealy et al., 2012). Children with ASD require unique care, ranging from specialized babysitters to social programs designed to manage needs inherent in their diagnosis of ASD. These services, programs, and personnel all have elevated costs that typical families have a hard time affording (Sansosti et al., 2012).

Independence and Dependence

Caring for a child who has ASD brings about unique challenges to their care. The uniqueness in the care needed for these children lies within the expression of the symptoms native to ASD alongside the mental health issues that often appear with an ASD diagnosis (Su et al., 2017). Parents who navigate these needs often anticipate solutions to their children's behaviors, which creates a level of dependency. This is echoed by a qualitative response by a parent in a study answering open-ended questions regarding their experience raising a child with ASD. Some participants stated specifically, "Horribly, every minute is spent figuring out how to help him. We have no life, our independence has been taken away" (Myers et al., 2009, p. 679). This dynamic of dependence continues throughout the development of the child, and eventually, issues of overinvolvement between parent and child exist as parents did not learn to separate out their behaviors from their child's (Hsiao, 2018).

Rigidity and Sameness of Routines

A diagnosis of ASD is often difficult to render by health care professionals, as the variability of presenting behaviors compounded by racial, cultural, and familial norms affect how the individual being

evaluated is interpreted. Despite these nuances, there are several characteristics, especially restricted and repetitive interest, that all individuals demonstrate (Spain et al., 2017). The rigidity of what topic is liked, and the range of interests, create both a level of attachment with the topic or object but also bring about extreme anxiety and dysregulation if it is not engaged in (Norton & Drew, 1994). This anxiety and dysregulation in the individual can affect family dynamics and parental well-being. For example, a qualitative response to a survey for parents of children with ASD stated, "We have difficulty on trips, in the car, at home, in the morning, after school . . . basically the whole date. We are ruled by his fixations and behaviors" (Myers et al., 2009, p. 675).

Parental Support

Parents of children with special needs, specifically ASD, have shown greater needs for support. It is also clear from the literature that lower levels of parental support (social, community, partner, familial) compounded with behavior that is unrelenting and maladaptive leads to higher levels of parental stress (Miranda et al., 2019). This is further supported by qualitative reflections in a study about parents with children with ASD where a participant stated, "People do not welcome us in their homes or do not want to go out with us" (Myers et al., p. 681). The loss of this community and connection with others described by the participant is a necessity to parental wellness and is a clear contributor to parental stress when absent (Hsiao, 2018).

Use of Coping Skills

Coping skills, or the use of coping mechanisms, can be defined as any labor or actions—emotional, cognitive, or behavioral—that aim to mitigate stressful events or emotional reactions (Zablotsky et al., 2013). Research has shown that coping strategies that are appropriate and tailored toward addressing the unique stressors that parents with children who have ASD, alongside adequate support from extended family, friends, and community, leads to a reduction of parental stress and other mental health pressures (Hartley et al., 2011; Hsiao, 2017; Kiami & Goodgold, 2017; Miranda et al., 2019). While the research is

clear on the need for coping skills to be present, there is little to no research that measures why some parents can effectively reduce their parental stress to subclinical levels while many others do not. The inclusion of parents in treating children who have ASD may provide insight if there is a reduction of any parental stress or mental health issues.

Anxiety in Parents of Children Who Have ASD

The literature is clear that raising a child with ASD is an arduous task that requires various levels of support and a community to conjure resources from because of the intensity of the task, and parents will experience increased parental stress along with a host of other mental health issues if left unchecked or untreated (Zablotsky et al., 2013). What is unclear and remains unstudied are the anxiety levels of parents who have children with ASD. The gap in the literature creates relationships regarding parental stress; however, this study will seek to investigate if the possibility of untreated parental stress, lack of support, lack of effective coping skills, and the myriad of demands that outweigh parental resources are contributors to high or clinical levels of anxiety in parents who have children with ASD (Zablotsky et al., 2013).

Anxiety in Children with ASD

Anxiety in children who have ASD remains an issue that, while it has been researched and identified as a concern, has not yet been espoused as a necessary target for treatment alongside other treatments that address issues like activities of daily living (White et al., 2009). While some medical professionals state that many of the symptoms of anxiety can better be explained by symptoms and phenotypical expression of ASD, it is unfair to overlook that individuals, particularly children, are unaware of their own difficulties connecting socially with others and experience anxiety as peer and family relations have an impact on individuals with ASD (Kelly et al., 2008; White et al., 2009).

Grief and Loss

Grief can be described as an emotional experience that causes deep distress, anguish, and sorrow that can be intense and far-reaching (Merriam-Webster, n.d.-a). Loss can be described as separation from,

being denied, eroded, missing, or unable to preserve (Merriam-Webster, n.d.-b). The concepts of grief and loss are common, and most individuals have a definition for them; however, for the purpose of this study, an enhancement and focus on these terms will assist in understanding the nuances of how grief and loss with families who have a child with ASD experience life. Many researchers have concluded that parents and families who have children with ASD suffer not just from grief and loss, but grief from the ambiguous loss (O'Brien, 2007). Ambiguous loss is a term used to describe the denial or departure of something meaningful from an individual, family, or community, but what is lost is vague, not clearly defined, or it lacks a definitive outcome (Boss, 2016; O'Brien, 2007). This ambiguous loss is far reaching, impacting various domains within parental and family life while continuously—through the lack of clarity during and after diagnosis, various sacrifices in the family life cycle, variability in the functioning of the child and family, and, lastly, the loss of relationships—creating cycles of grief during each milestone. Qualitative data collected in one study by Myers et al. (2009) captures how ambiguous loss creates a cycle of grief within some families. One participant stated, "I am often depressed, stressed, and grieve the child that I once imagined" (p. 677), while another stated, "[It] left me totally burned out, depressed, guilty, and overwhelmed." (p. 677).

Family Sacrifices

Many studies allude to or highlight the loss that families endure due to the impact of the ASD diagnosis. Primarily, ASD negatively impacts an individual's ability to perceive social cues in others, such as empathy or distress impeding their ability to connect based on that perception (Norton & Drew, 1994; O'Brien, 2007). This lack of connection is a sacrifice parents, siblings, and the children themselves face without consent. Moreover, the needs of the child with ASD are unpredictable and often unrelenting. The boundaries between the parents and child are often blurred and difficult to decipher (*boundary ambiguity*) as growth and development are not linear with a child with ASD (O'Brien, 2007). The constant and consistent rigidity and unknown view of the future build up over time, causing a sacrifice of time spent in

other relationships (community, extended family, and intimate relationships) in favor of centering the child's needs (Kiami & Goodgold, 2017).

MFT Work with ASD Families

In the realm of family therapy, there are a multitude of models that are effective, depending on the presenting issue, skills of the clinician, or culture of the agency.

> Family therapy can be defined as a formal, psychotherapeutic intervention, which seeks to understand and enhance relationships, communication, and functioning between members of a family. . .. It is hypothesized that the family unit and the relationships between family members are dynamic (that is, that the reactions and responses of one person affect those of others in the system, in a bi-directional fashion, linearly and longitudinally). Family therapists use a range of interventions, including psychoeducation; development of genograms to map out cultural, resilience or other familial patterns; narrative techniques (e.g., to explore language, meanings, and attributions); and the use of particular questioning styles (e.g., circular and reflexive questions to enhance the breadth and depth of discussion). (Spain et al., 2017, p. 1)

The interventions used by family therapists, alongside with how they conceptualize the problems of individual pathologies, represent new opportunities of how to view and treat children with ASD and their families. These interventions could also unite treating both the parents and child with ASD instead of parental issues such as stress and anxiety and the anxiety of the child with ASD.

The review of the literature regarding the work marriage and family therapists have done or have proposed in treating children with ASD along with their families is scarce. It appears that family therapy has not made its way fully into the realm of addressing ASD and the impact it may have on caregivers and siblings of children with ASD. However, the literature and studies that are present have made a significant impact (EFT, solution focused, SFT) in addressing the gap of information but none have included the

children, examined levels of anxiety, or the family structures and dynamics that may contribute to ASD symptomology.

Structural Family Therapy

"SFT (structural family therapy) is considered one of the original family therapy approaches that developed out of a systemic framework and continues to influence the practice of family therapy. The overarching goal of SFT is to alleviate distress among family members by restructuring the current family organization that has become maladaptive" (Parker & Molteni, 2017, p. 137). The review of research on SFT and its treatment of families with children with ASD reveal a number of areas that provide relief. The first area is family disengagement.

Disengagement is associated with overly rigid and impermeable boundaries that foster isolation and block mutual support among family members. Arguably, parents of children with autism are in even greater need of mutual support and interdependence than those of typically developing children due to the overwhelming parenting demands, shown to result in excessive levels of stress, anxiety, and depression (Parker & Molteni, 2017, p. 138).

Although distance can be a preventive and health measure for coping with stress in relationships, a consistently reliance on moving away from one's feelings when raising a child with ASD can be damaging to the relationship between caregiver(s) and child as well as the family relationship. The second target for treatment is enmeshment. Either of these extremes impact healthy family relationships.

Ramisch (2011) explains that families affected by autism may easily become enmeshed as a natural response to meeting the child's needs. Many of the deficits associated with ASD, such as problem solving and cognitive rigidity, suggests parents of children with autism must provide intensive care and protection far beyond what would be appropriate for a typically developing child (Parker & Molteni, 2017, p. 139).

Furthermore, boundary-making interventions directly intended to clarify diffuse boundaries between parent and child with ASD often disregard the demands and expectations associated with autism in the

family. Therapists must therefore reconceptualize enmeshment when working with families of children with autism (Parker & Molteni, 2017, p. 139–140). SFT offers a unique understanding of the level of closeness that is inherent when caring for a child with ASD. SFT gives space to not pathologize the emotional proximity of parent and child but to reshape it as a way of healthy functioning. Lastly, SFT speaks about restructuring interventions. "As opposed to relying on the family's report of the concerns, boundary-making interventions allow the family to experience their current and alternative interactions during the session" (Parker & Molteni, 2017, p. 140). Allowing caregivers, parents, children with ASD and their siblings the opportunity to experience each other in ways that are not necessarily dictated through the lens of ASD is a powerful, relational-shifting intervention that can have profound effects in increasing family stability and cohesion, as well as ensuring that parents are able to be flexible with their roles as caregivers.

While many theories are a suitable fit to do the needed work with families who have children with autism spectrum disorder, SFT seems to be the most appropriate fit. SFT is centered on creating clear boundaries for all members of the family system, restoring appropriate hierarchies between parent and child, and using intensity through all interventions. Structural family therapists are able to address the power imbalances that are native to how family members organize around symptoms of autism spectrum disorder. SFT is also able to help connect family members emotionally, giving them an increased level of resilience needed to face movement through the family life cycle (births, deaths, marriage, launching, etc.). Lastly, SFT can support couples' work, recreating a balance in expectations and division of labor in caregiving roles and responsibilities.

Currently, there has been some work and research around family therapy and autism spectrum disorder, but it is not a mainstream and preferred model of treatment (Brockman et al., 2016; Connolly et al., 2018; Lee et al., 2017; Moghaddam et al., 2016; Parker & Molteni, 2017; Ramshini et al., 2018; Sheinkopf & Siegel, 1998; Smock-Jordan & Turns, 2016; Solomon et al., 2008; Thompson et al., 2014; Turns et al., 2019; Turns et al., 2016; Wagner et al., 2019). These studies and writings highlight that ASD

has a wide range of complications that impact the relationships of families, which have direct impacts on parental well-being and on siblings of individuals who have ASD. Furthermore, these researchers display, in theoretical terms, appropriate ways to manage, treat, and address the symptomology that arises from the systemic impact of ASD on families.

Based on the existing review of the literature, the needs of parents of children with ASD can be extreme, overwhelming, and far-reaching—specifically, issues such as parental anxiety brought about by extreme role overload, dysfunction in sibling relationships due to presenting behaviors, and the rigidity of boundaries and communication native in families with children with ASD. These are unique challenges that necessitate the need for the inclusion of family-based treatment. This study will specifically examine four areas:

1. Is SFT an appropriate therapeutic model to address rigidity of family systems with children who have ASD?
2. Is SFT an appropriate therapeutic model to alleviate family based (parent + child) anxiety with a family who has a child with ASD?
3. Will SFT address and adjust family cohesion and family adaptability allowing for family-based anxiety to decrease?
4. Can SFT increase family cohesion and family adaptability?

CHAPTER III: METHOD

The original method proposed for this study was to be a limited clinical trial, recruiting families who had children with ASD to receive family therapy. Eligible families were to be randomly assigned to an experimental or waitlist group. Measures would be collected pre- and post-intervention/therapy. Data would have been analyzed using Analysis of Variance (ANOVA) to confirm what changes, if any, occurred. Recruitment for the study yielded great enthusiasm from potential families but, ultimately, many families did not follow through on completing paperwork. Of the families that followed through, to date, five families began therapy, which allowed the first baseline measures to be collected. Of these five, only one family was able to continue through the 10-session requirement. To that end, the methodology of this research study needed to be changed to reflect the findings of the one family who, to date, has completed the 10 sessions. The newly reconfigured study is a single case experiment and is the first of its kind. The study aims to demonstrate the efficacy of SFT, investigate if SFT is able to decrease anxiety in families who have children with ASD, and if family-based treatment is appropriate for families who have children with ASD. The study is a Single Case Experiment (SCE) design. SCE's have been utilized in research for over 50 years and have provided great insight as to how effective a particular treatment intervention may be and to demonstrate intervention effectiveness in pilot studies (Hilliard, 1993; Krasny-Pacini & Evans, 2018; Thyer & Curtis, 1983). SCE designs demonstrate the effectiveness of interventions through repeated measures across time that span, at minimum, three phases: baseline, treatment, and post-treatment (Dickey, 1996; Kratochwill et al., 2010). Analysis of data that is identified through measures that are appropriately chosen to answer hypothetical questions are mainly achieved through visual analysis (Kratochwill et al., 2010; Lenz, 2015). This study centered on one family (case) where SFT has been administered in a biweekly fashion and packaged as intensive family therapy. Each session was 90 minutes in duration, split such that 45 minutes were dedicated to therapy with every family member and 45 minutes were dedicated to therapy with the parents only. Data was collected prior to the first session (baseline), before the fifth

session (treatment which is represented by the 4-step assessment and family restructuring interventions), and lastly after the tenth session had elapsed. The measures used were the Anxiety Scale for Children–autism spectrum disorder-child version (ASC-ASD; Rodgers, et al., 2016), the Anxiety Scale for Children–autism spectrum disorder-parent version (ASC-ASD; Rodgers, et al., 2016), and the Family Adaptability and Cohesion Scale (FACES-IV; Olson, 2011).

Participants for this study were recruited from the local Seattle community and beyond through means of advertising the parameters of this study. Flyers, emails, and other advertisements were sent to medical doctor's offices, the University of Washington Autism Center for Human Development, Seattle Children's Hospital, ABA centers, and various other medical facilities across the state, as participant families had the ability to participate in the study via telebehavioral health. Once participants had been selected for this study, they could receive services immediately.

Participants

The study was open to participants from any constellation of family structure—that is, single parents, same-sex parents, heterosexual parents, and grandparent functioning as the main caregivers. Families needed to have at least one child residing with them who had confirmation of a diagnosis of autism spectrum disorder and is currently receiving ABA services. The goal of this study was to successfully recruit 8–10 families who are diverse in race and culture. Participant's demographics were collected asking their age, sex, gender, religion, race, ethnicity, and severity of ASD in the child. Prior to being accepted into the study, parents and children were screened for anxiety, depression, and other mental health issues, which may have been too excessive and would best refer out to other providers (no families were screened out). This step was essential to protect the health and safety of respondents who desired to be a part of the study but who may be best served with receiving other services prior to being eligible to subsequent family-based treatment. The Patient Health Questionnaire-9 (PHQ-9; Kroenke and Spitzer, 2002) was used to screen for levels of depression with results of severe depression with a score range of 20–27. Scores higher than 20

were referred out for individual-based treatment. In addition, the Generalized Anxiety Disorder (GAD-7; Spitzer et al., 2006) was used to screen for levels of anxiety with results of severe anxiety with a score range of 15–21. Scores higher than 16 were referred out for individual-based treatment.

Families that were successfully selected for this study were given an informed consent that detailed how participant protection was embedded into the process. First, participants were informed that no study is without risk, but there is no expectation that this study will result in harm or distress for families. Participants identifying information were not part of the pre- and post-measurements that were given during the study, and the data was de-identified to protect confidentiality. However, there were limits to the confidentiality of this study. Confidentiality is broken in psychotherapy when there is imminent harm to an individual or another named person. The clinician (a master's student) in this study did not need to break confidentiality and complied with the Washington State law of mandated reporting. Special care was highlighted in the study protocol and informed consent to detail special protections for child participants. Any individual under the age of 18 years old had consent from their parents to participate in this study. Additionally, children over the age of 13 years old were able to consent for treatment without parental acknowledgement, consistent with Washington State law. Participants were informed of the potential benefits of this study, which includes the ability to receive mental health treatment using an evidence-informed treatment to alleviate mental health issues by supervised therapist interns.

As stated previously, the attrition levels of families were extremely high and complicated the ability to secure data. Thus, a shift in research design was needed to reflect the landscape of treatment participation. At that time, of the five families that began the process, only one family expressed and demonstrated that they would be able to complete the entire ten sessions. A transition of the study to an SCE was appropriate, as it gave the researcher the ability to collect and analyze the data.

The family received ten sessions of treatment. Due to the ongoing COVID pandemic, telebehavioral services were given to participants. Every session was recorded and will be used as training material.

Participants signed a separate consent form, allowing for recordings to take place, and they had the option to decline and still take advantage of the treatment.

Treatment

The family received intensive family therapy using SFT as the modality. Sessions were biweekly in frequency and were 90 minutes (45 minutes for the entire family and 45 minutes for parental support/therapy). Therapy lasted for 10 sessions, with an elapsed time of five weeks in total.

Treatment Protocol

All families received SFT. Each parent together completed the ASC-ASD—Parent version (one form per family), the child version for those children who were unable to do so, and the FACES-IV scale (done as a family unit) prior to the commencement of treatment. After the fourth and tenth sessions of treatment had elapsed, families again completed the scales. Data was collected from families with children who have ASD. The ASC-ASD (parent and child) and FACES-IV were given to the family three times. The first was prior to the commencement of treatment which acted as a baseline measurement. The second was after 5 session weeks had elapsed, signaling the midpoint of treatment. The last measurement was administered two weeks after the last session.

Treatment for the augmented group followed the tenets of structural family therapy according to *Family therapy techniques* (Minuchin & Fishman, 1981). Therapists were master's level student therapists who were enrolled at Antioch University Seattle, who expressed an interest in treating ASD systemically, and who received 30 hours of structural family therapy theory and ASD symptomology training from the principal investigator. This family started and ended with the same therapist.

Measures

Anxiety Scale for Children—autism spectrum disorder

The study used the ASC-ASD parent and child versions (Rodgers, et al., 2016) to assess anxiety levels in both the parent of a child with ASD as well as the child with ASD. Both measures are 24-item self-

administered questionnaires that accurately gauge the level of anxiety present in the individual. The scale is Likert in type and ranges from 0 (Never) to 3 (Always). The scale also contained four subscales—Separation Anxiety, Uncertainty, Performance Anxiety and Anxious Arousal—but they were not used in this study. Only sum scores were utilized. The ASC-ASD has demonstrated a Cronbach's alpha score of .94 for the parent full scale and .94 for the child version (Rodgers et al., 2016). Furthermore, the ASC-ASD was utilized in the longitudinal study of Australian students with autism where they confirmed the measure accurately discerned between autistic behaviors and anxiety and rendered a Cronbach's alpha score of .93 (Den Houting et al., 2018)

Family Adaptability and Cohesion Evaluation Scales

The FACES-IV (Olson, 2011) is a scale that measures family functioning through cohesion and flexibility. These two dimensions of the scale are divided into two subscales, Balanced and Unbalanced Scales. Within the Balanced scales, the measure highlights the level of cohesion and flexibility. Cohesion is defined as the level of emotional bonding present in the family. Flexibility is defined as the quality and expression of leadership and organization, role relationship, relationship rules, and negotiations. Within the Unbalanced scales, the measure highlights the level of Enmeshment, Disengagement, Rigidity, and Chaos. Reliability of the subscales within the measure found alpha reliability values of .77 for Enmeshed, .87 for Disengaged, .89 for Balanced Cohesion, .86 for Chaotic, .84 for Balanced Flexibility and .82 for Rigid (Olson, 2011). To provide focus in data collection of this study, the ratio scores will be used to measure change in family cohesion, flexibility, and communication. The family submitted one measure per time period of which the entire family dedicated time to come to an answer for each entry. Below the scales (Enmeshment, Disengagement, Rigidity, Chaos, Balanced Cohesion and Flexibility) are described in detail.

Additional Qualitative Questions

Open-ended questions regarding:

1. the families' experiences of therapy

2. Current maladaptive behaviors of children with ASD

were gathered and analyzed to supplement the explanation of change, if any, qualitatively.

Analytic Strategy

Preceding the commencement of the pilot study, participants were screened for inclusion in the study. Prior to treatment, the family received information about the study. The ASC-ASD (parent and child versions) and FACES-IV measures were given, tracking their baseline, treatment, and post-treatment levels. After the last timepoint, the case was analyzed visually to investigate the outcome of the experiment.

Data Preparation and Analysis

The preliminary tests conducted included visual analysis. In addition, investigators will check univariate and multivariate assumptions. Data was collected from all parents (ASC-ASD parent version is one form per family) participants and measures, ASC-ASD (parent and child version) and FACES-IV, were given three times (Baseline, Treatment and Post-Treatment). Visual analysis of the data via graphs provided explanation of the study.

Ethical and Diversity Considerations

This pilot study adhered to the highest ethical standards put in place by the Belmont Report, IRB panel of Antioch University, and APA. Participant protection and commitment to adding benefit to participant well-being were at the forefront of this research. In addition, researchers associated with this pilot were mindful of ensuring that the purpose of this treatment was to create increased wellness in parents of children with special needs.

This pilot boasted two areas of ethical strength. The first was the development of a model of treatment that incorporates wellness of families of children with special needs that is addressed outside of the medical model of individual-based pathology and treatment. Should the results demonstrate a decrease in ASD symptomology and anxiety and an increase in family cohesion, this would increase justification of systemic-based interventions to treat children with special needs. The second was the inclusion of family

compositions of all constellations. This pilot sought to involve and include families from all backgrounds (same-sex, heterosexual, single-parent, various race and ethnicity).

The primary purpose of this study was to examine if family-based anxiety could be alleviated in families who have children with autism through the lens of a single case experiment. The method of intervention was the use of SFT, which centers on promoting a strong executive subsystem (parental relationship and alliance), clear boundaries between the individuals of the system, and positioning the family to harvest their natural resiliency to address presenting problems. In addition, this study sought to examine the effectiveness of SFT in families as a means to bring about the goal above.

CHAPTER IV: RESULTS

Case Description

The current study observes the case of cisgender heterosexual couple Salvador and Matilda, who have been married for 10 years. They have no biological children but adopted their son, Derek (12 years old at the time of treatment) at birth. The adoption was "open," and the couple adopted Derek from a close family acquaintance. Derek, as well as Salvador and Matilda, still maintains contact with Derek's biological parents. Matilda is home with Derek while Salvador works full time. The family is middle- to upper-class socially and have passive religious/spiritual adherence. They have confirmed Derek's diagnosis of ASD when he was 7 years old as they noticed during grades 1–4 that he struggled greatly both behaviorally and emotionally in all environments, particularly in school. Matilda reports that she has a history of trauma, and that alcoholism and depression are prevalent in her family. Salvador did not report any historical issues present within his family. The family is a white family, which includes the race of Derek.

The family entered treatment in this study to address some of the behaviors they believe are tied to Derek's ASD diagnosis. Derek has a history of emotional dysregulation, high levels of energy, trouble focusing, and becoming extremely angry. Since adolescence, he now struggles greatly within the academic realm, failing to complete his homework, and he needs substantive support to demonstrate proficiency in school. The family stated that they do not have a comprehensive approach as to how to support or address Derek's issues. Salvador reports that he desires more structure and consequences, whereas Matilda believes that Derek needs more emotional support. Derek states that he believes his father is extremely hard on him and feels misunderstood by him.

In therapy, the family had an initial treatment goal of addressing Derek's activities of daily living. Once the initial sessions had occurred and the 4-step assessment process within SFT elapsed, the therapist expanded on the presenting problems in the system. They were:

1. The parents were extremely stressed and concerned about their divergent ways of parenting and discipline. One parent was the sole disciplinarian while the other was the emotional mediator.
2. The parents were worried about how ASD was and would impact their child's life as he struggled with issues that other typical children did not.
3. The entire family expressed concern regarding how fraught their relationships were and wondered if they would always be this way. Much of the relationship difficulties centered around ASD and the impact of the diagnosis on the family.
4. Lastly, the child expressed anger that they were unable to approach their parents in their current dynamic and wished for relief.

These issues were tackled head-on by the therapist and with SFT. The therapist first concentrated on strengthening the parental subsystem by inviting Matilda to dialogue with Salvador about their emotional connection, vision of parenting, and concerns about parenting. The therapist clarified boundaries by examining where enmeshed dynamics caused parent and child to form coalitions instead of the parents remaining united. The therapist also used structural interventions such as intensity, highlighting and modifying interactions, and unbalancing where necessary and according with the training they received. Lastly, the family received systemically transformed psychoeducation about the impacts of ASD on the family and family dynamics. Qualitative data was gathered prior to and post-treatment.

SFT is a systemically aligned model of family therapy that draws on the resilience of families by reorganizing their structure to enhance their roles and rules. This is mainly done by a structural family therapist creating clarity of communication and boundaries in the family system while also increasing the flexibility of the family system itself. According to SFT, families are unable to access their natural resources to problem-solve due to the rigidity of their boundaries, roles, and rules. That is to say that their lack of reflexivity limits them from addressing the problem at hand.

This study is a pilot study and sought to apply systemic treatment to an underserved population, families who have children with ASD. The study examined if the use of SFT could provide a beneficial therapeutic effect to families who have children with ASD by lowering anxiety and depression and decreasing the rigidity of family dynamics.

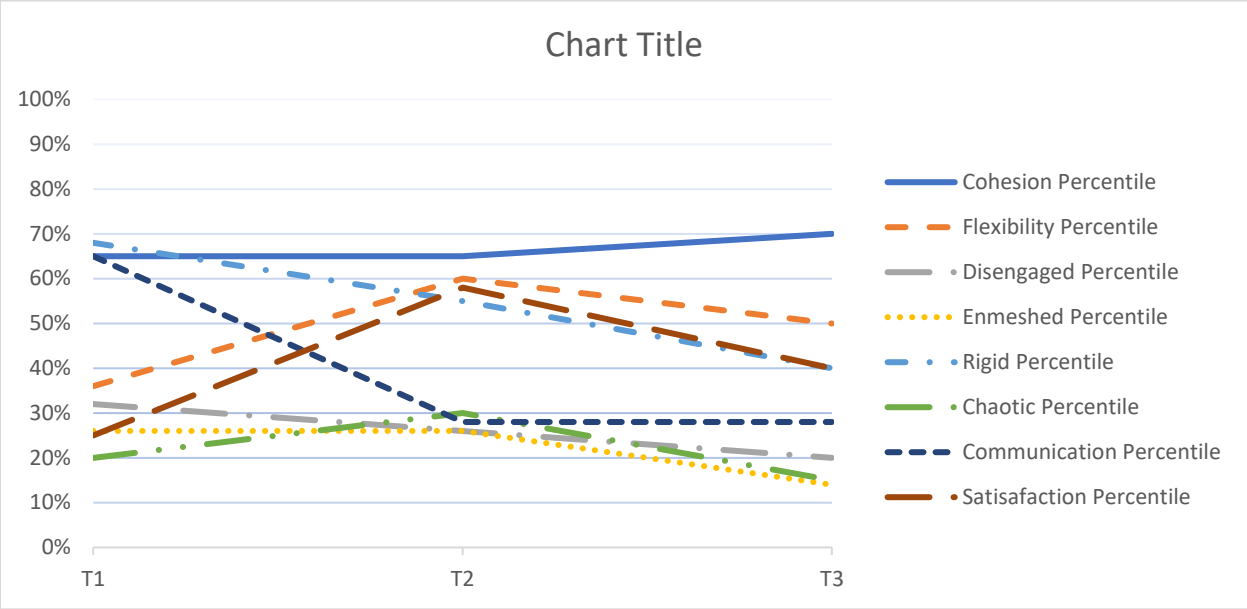
Visual Analysis of Findings

The family successfully completed treatment, and their data was compiled and analyzed visually, which is the prescribed technique in single case experiments. Below are visual findings of the FACES-IV and ASC-ASD measures.

The FACES-IV measure has several subscales that are represented below in the graph. The subscales are as follows: Balanced Cohesion, Balanced Flexibility, Disengaged, Enmeshed, Rigid, Chaotic, Family Communication, and Family Satisfaction. Each subscale has a raw score and weighted percentage based on the raw score that can then be translated into a rating that ranges from Very Low to Very High, with the exceptions of Balanced Cohesion, which ranges from Somewhat Connected to Very Connected, and Balanced Flexibility, which ranges from Somewhat Flexibility to Very Flexible.

Figure 10

Complete Trajectory of FACES-IV Percentiles

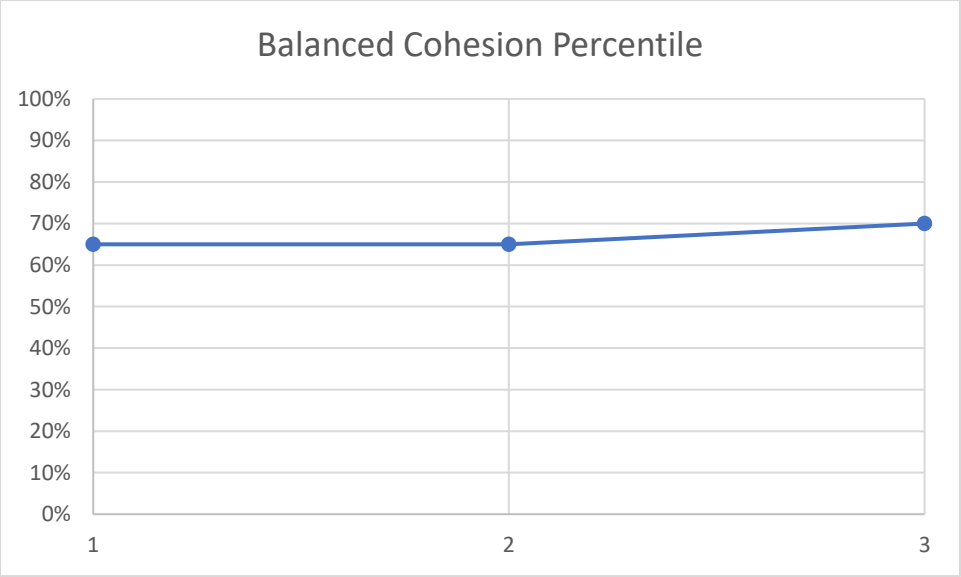


Balanced Cohesion

Balanced Cohesion refers to the levels of independence and closeness of family members. These values for this subscale stayed relatively static across timepoints in raw scores, 28 (65%—Connected ranging from Somewhat Connected to Very Connected), 28 (65%—Connected) and 27 (70%—Connected). A 5% increase in percentage was present for levels of cohesion in the family (Olsen, 2011).

Figure 11

Balanced Cohesion Percentile

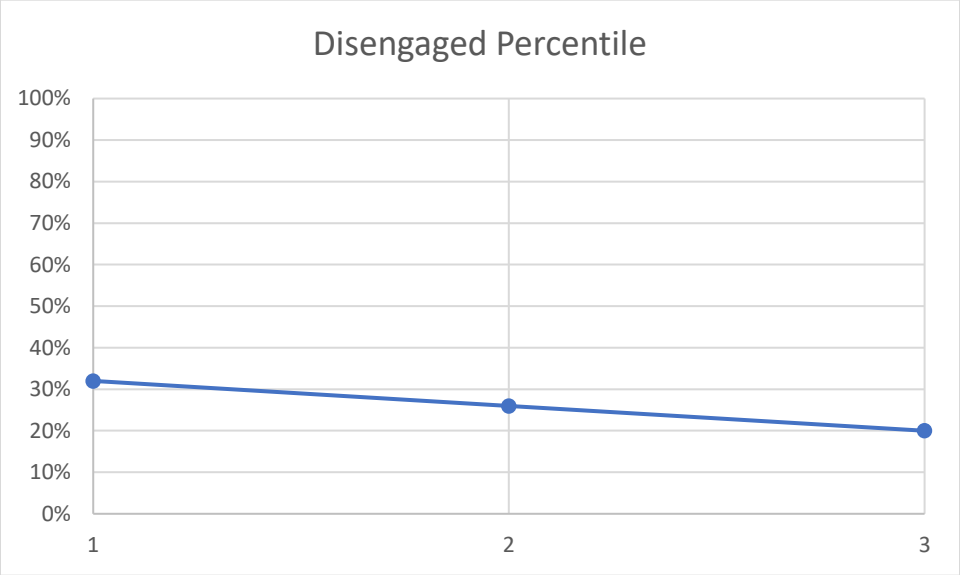


Disengagement

The Disengaged scale measures levels of distance emotionally of family members and the family system (Olson, 2011). The values for this subscale were 18 (32%—Low), 16 (26%—Very Low) and 14 (20%—Very Low). A noticeable decrease in disengagement levels were seen during treatment.

Figure 3

Disengaged Percentile

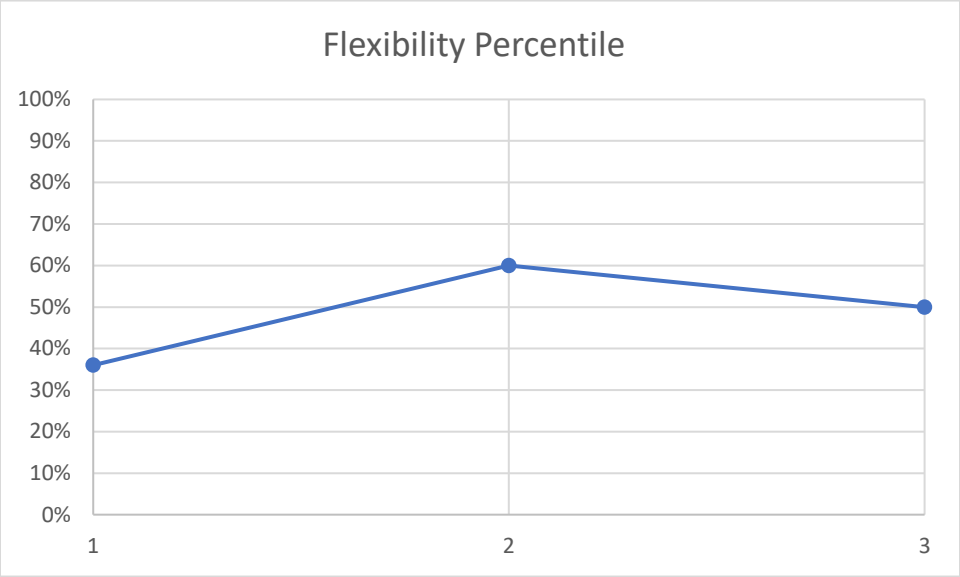


Flexibility

The Flexibility scale assess the range of plasticity in family roles both on the individual level and as a family (Olson, 2011). Too much flexibility creates a permissive environment where disengagement of relationships flourish. Too little flexibility creates rigidity in family dynamics. The values for this subscale were 19 (36%—Somewhat Flexible), 26 (60%—Higher end of Somewhat Flexible), and 23 (50%—Midpoint of Somewhat Flexible). Overall, the levels of flexibility rose in the family. Flexibility refers to the levels of change in family rules, dynamics, leadership, and roles. These values for this subscale were 19 (36% at Flexible-Low End), 26 (60% at Flexible-High End), and 23 (50% at Flexible-Mid level). A noticeable increase of flexibility was seen during the course of treatment.

Figure 4

Flexibility Percentile

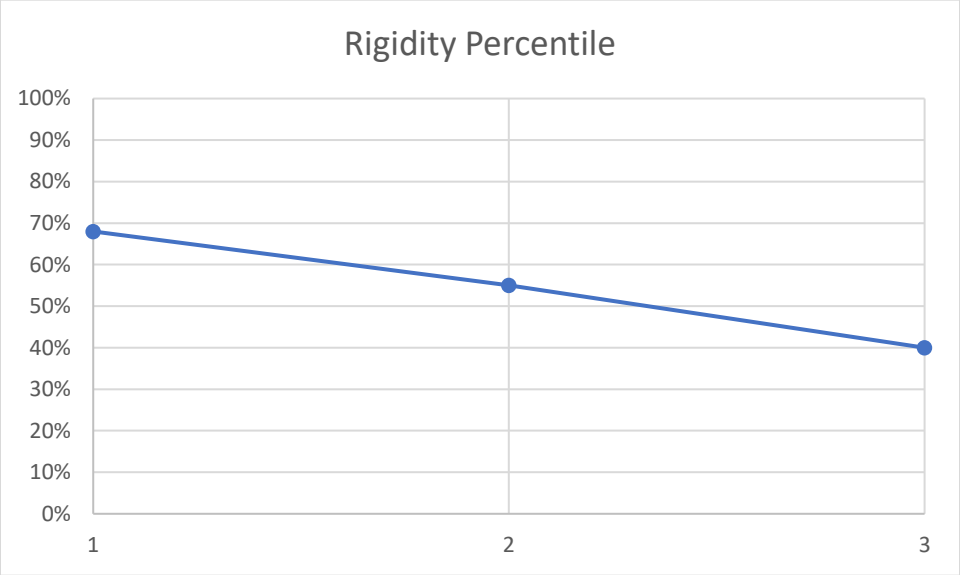


Rigidity

The Rigidity scale measures how much change the family system can accommodate (Olson, 2011). While not necessarily a maladaptive trait in a family, too much rigidity prevents families from being able navigate problems. The values for this subscale were 27 (68%—High), 24 (55%—Moderate) and 21 (40%—Very Low). A noticeable decrease in family rigidity was seen during the course of treatment.

Figure 12

Rigidity Percentile

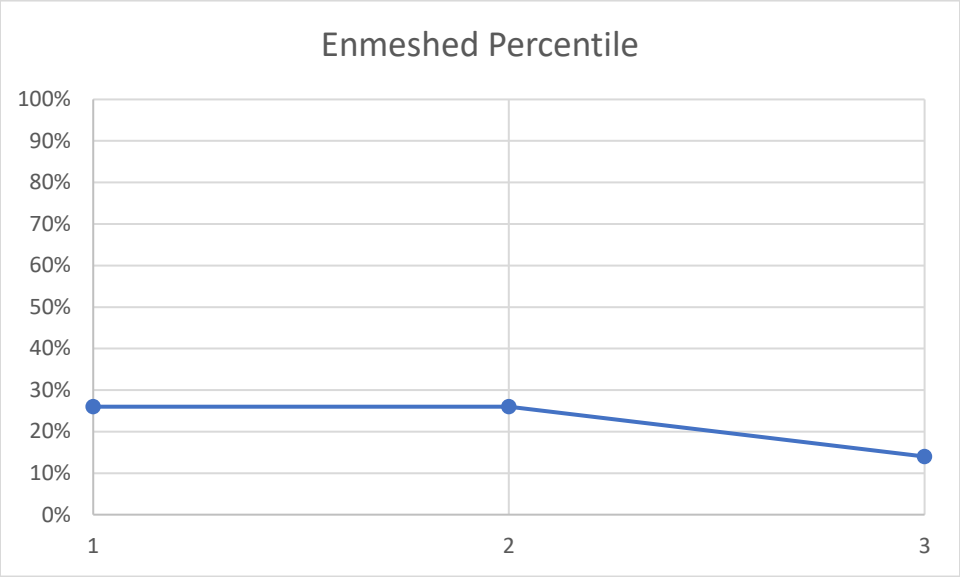


Enmeshment

The Enmeshment scale measures the closeness and overlap of emotional distance between family members (Olson, 2011). While not necessarily a maladaptive trait in a family, too much enmeshment prevents individual family members from being able to differentiate between their own boundaries and others. The values for this subscale were 16 (26%—Higher end of Very Low), 16 (26%—Higher end of Very Low) and 10 (10%—Bottom of Very Low). There was a downward trend of enmeshment in the family over time.

Figure 6

Enmeshment Percentile

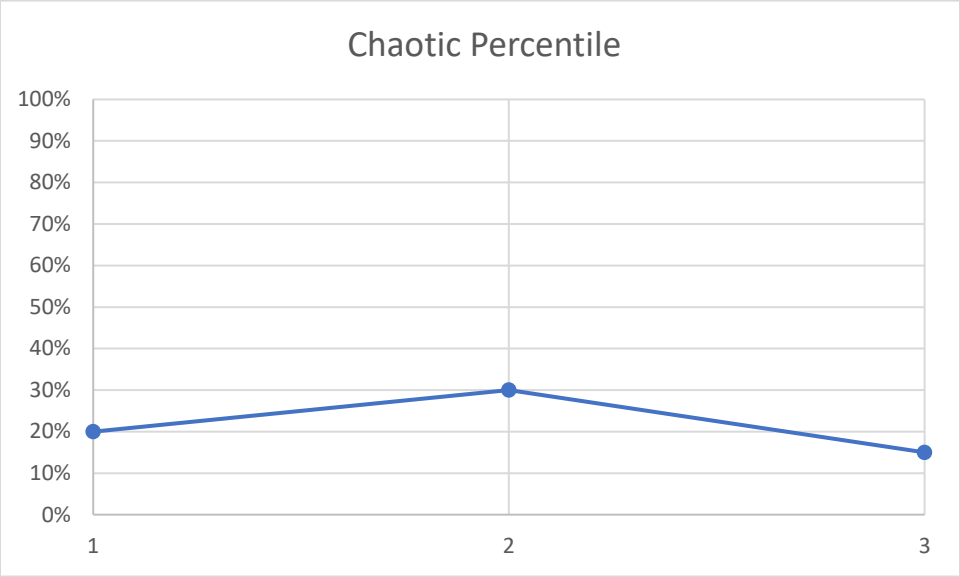


Chaotic

The Chaotic scale measures levels of disorganization and the clarity of rules and the environment of the family (Olson, 2011). The values for this subscale were 14 (20%—Very Low), 17 (30%—Low) and 11 (15%—Very Low). During treatment, levels of chaos increased but fell below the baseline timepoint at termination.

Figure 13

Chaotic Percentile

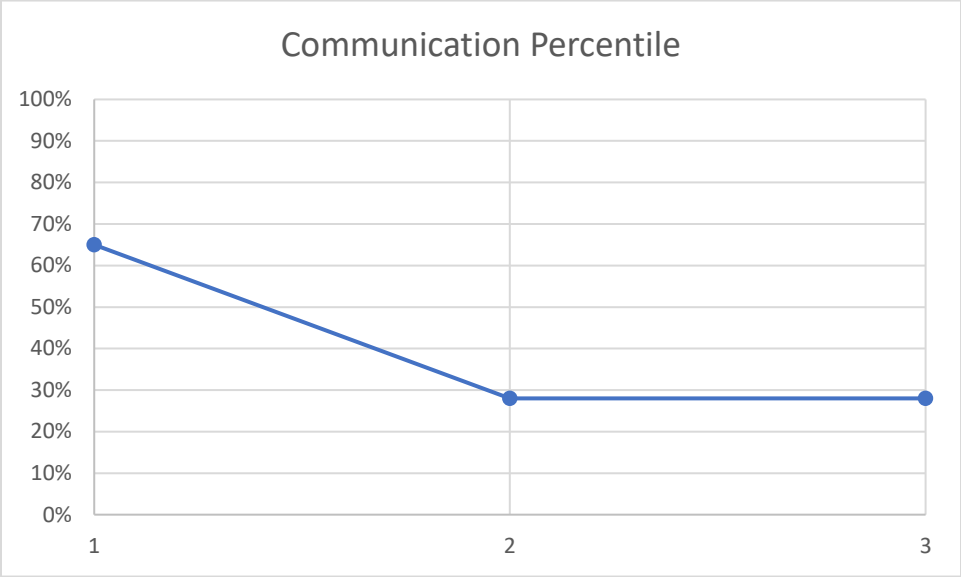


Family Communication

Family Communication measures the levels of and quality of information throughout the family system (Olson, 2011). The values for this subscale were 39 (65%—High), 31 (28%—Low) and 31 (28%—Low). There was a perceived decrease in the levels of communication of the family during and after treatment.

Figure 14

Communication Percentile

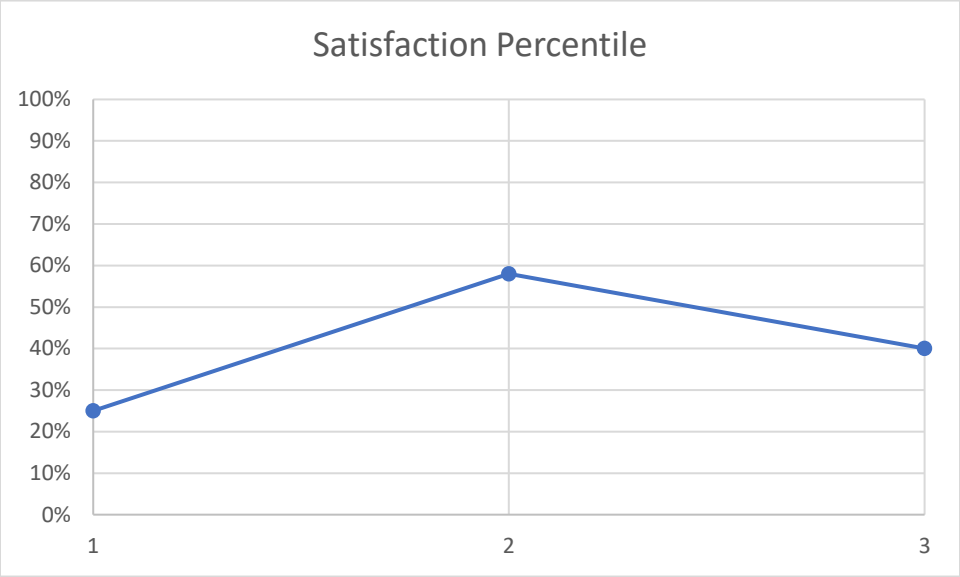


Family Satisfaction

Lastly, Family Satisfaction measures how pleased family members are in their relationships with each other (Olson, 2011). The values for this subscale were 32 (25%—Low), 39 (58%—Moderate) and 36 (40%—Moderate). Levels of satisfaction trended upward and stayed relatively well above baseline measures post treatment.

Figure 15

Satisfaction Percentile



Parent/Child Anxiety

The ASC-ASD were given for parents (one measure for both parents) and children. Below the scores across treatment are displayed:

Figure 16

ASC-ASD Score—Parent Version

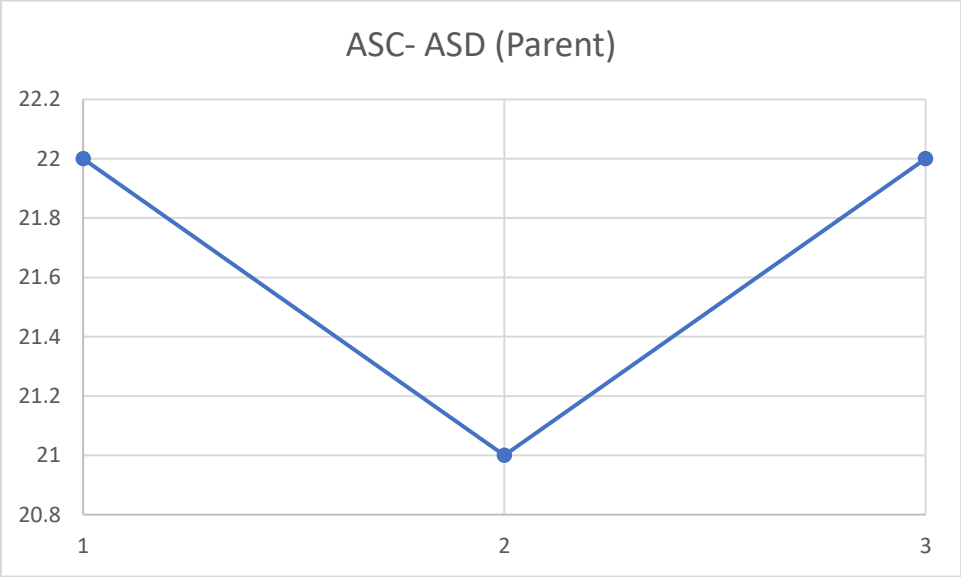
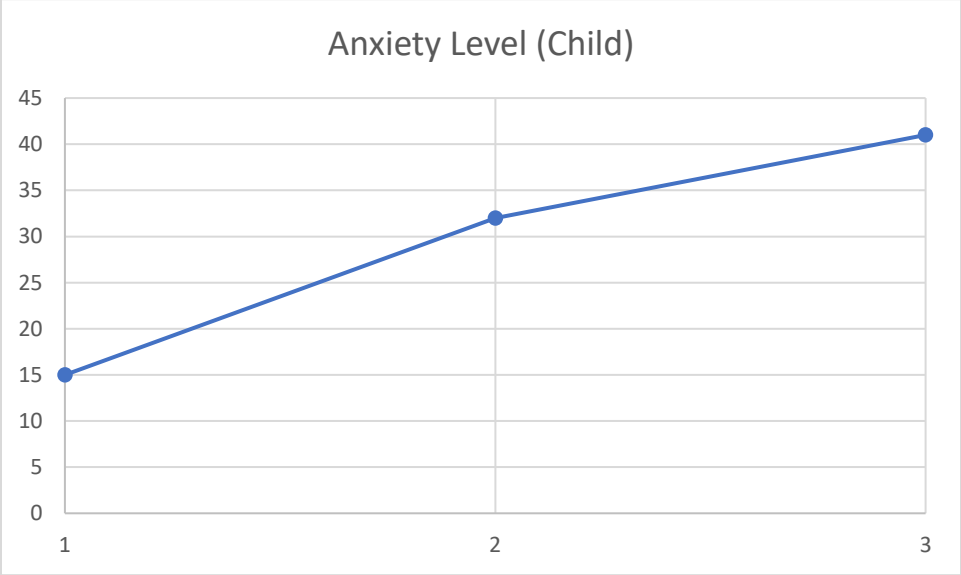


Figure 17

ASC-ASD—Child Version



The parental rating of their child's anxiety remained relatively the same from baseline to post treatment, while the child's rating of their own anxiety steadily increased over the study.

The family also answered brief open-ended questions regarding this experience in therapy. The parents were asked, “In what ways, if any, has this approach of making space for an supporting the family in sessions together been helpful, impactful, or meaningful?” The parents answered, “We liked being able to talk through things. We feel like we understand our child’s feelings more and feel like we understand his diagnosis more.” The child with ASD was also asked about his experience of family-based therapy and he replied, “I liked the therapy. I feel like my dad understands what I need.”

CHAPTER V: DISCUSSION

The purpose of this study is to examine if SFT is a suitable model of therapy to address family-based anxiety within families who have a child with ASD. Existing literature reveals that parents often experience heightened levels of depression, anxiety, stress, fatigue, and a host of other issues that directly impact their mental well-being (Zablotsky et al., 2013). Many times, these stressors are related to issues of securing a diagnosis, navigating the system of care post-diagnosis, and the inability for parents to have a safe place to process through their grief and loss (Spain et al., 2017). Likewise, other individuals in the family system of children who have ASD (including the child with ASD), experience higher levels of anxiety and depression due to the systemic impacts of ASD on the family (Myers et al., 2009). Lastly, children with ASD are often comorbid with other mental health issues, which generally are not addressed as formal treatment for ASD (Govind, 2018). The current treatment protocol for children who have ASD is generally the referral to ABA services, which is appropriate in some respects but fails drastically short in addressing the systemic issues present for families who have a child with ASD.

Summary of Findings

This single-case experimental study demonstrated that while SFT was not effective in lowering anxiety in this child who has ASD as well as in their parents, the family did demonstrate a decrease in their levels of rigidity while seeing noteworthy increases in their levels of flexibility, cohesion, and family satisfaction. Moreover, through treatment, the family saw a reduction in the levels of enmeshment, chaos, and disengagement while seeing lower levels of family communication. Lastly, this study demonstrated that SFT is a suitable model of treatment for families who have children with ASD to address systemic impacts of ASD on the family, which addresses a previous gap in clinical practice and treatment protocols. In an effort to succinctly address how this study advanced knowledge of treating ASD, the research questions will be revisited.

Research Question 1: Is SFT an appropriate therapeutic model to address rigidity of family systems with children who have ASD?

In this study, the answer to this question was yes. SFT was an appropriately selected model to decrease rigidity of family systems with children who have ASD. This was evident in the decrease in rigidity levels of the family on their FACES-IV scores. SFT (Colapinto, 2019), by its very theoretical tenets, describe various interventions that are designed to empower families to visit their rules and regulations which, if rigid in manner, keep the response to problems the same.

Research Question 2: Is SFT an appropriate therapeutic model to alleviate family based (parent + child) anxiety with a family who has a child with ASD?

In this study, the answer to this question was no. Both parent and child's perception of anxiety levels were increased during the study period. However, it is important to note that the work of changing oneself (Kiecolt, 1994) and/or family dynamics can be of great stress during the therapeutic process.

Research Question 3: Will SFT address and adjust family cohesion and family adaptability allowing for family-based anxiety to decrease?

In this study, the answer to this question was partially. This family did see an increase in their family cohesion and flexibility levels (adaptability), but this did not translate into a decrease in family-based anxiety. Perhaps given more time to journey through the process of change, the increase of cohesion and adaptability would have led to a decrease of anxiety.

Research Question 4: Can SFT increase family cohesion and family adaptability?

In this study, the answer to this question was yes. This family did see an increase in their cohesion and adaptability levels (Cohesion + Flexibility). Again, we see here the theoretical interventions (specifically highlighting and modifying interactions) of SFT (Colapinto, 2019) producing outcomes which increase wellness for the family.

Discussion

Foundational theories of family therapy have positioned the MFT profession as leaders in systemic treatment and intervention. However, many of these models declared efficacy through continued use by clinicians but have not been tested empirically (Sprenkle, 2012). This study utilized SFT and, in this individual case, demonstrated efficacy in several areas that make a difference in the lives of families. SFT was shown to be a relevant model for therapist use through this efficacy. SFT often has fallen to the wayside as a model that is seen as archaic, or which reinforces patriarchy in some form (Vetere, 2001). This study demonstrates that SFT continues to be a relevant and useful theory to treat current issues of families. SFT gives the therapist additional tools to address numerous issues that plague families who have children with ASD, ranging from anxiety and depression, by adjusting the structure of a family. There was clear liberation for this family to reimagine how their relationships could be transformed by increasing inner protective factors (flexibility, cohesion, and satisfaction [Baer, 2002; Rosnati & Marta, 1997; Van Schoors, et al., 2019]) while decreasing threats to unbalanced family dynamics (high rigidity and enmeshment; Velasco et al., 1983) in factors that prevent clear boundaries, communication, and functioning. For example, the levels of rigidity in the family were very high prior to the beginning of treatment. Based on the existing literature, there is common knowledge that families organize transitions and other activities around the demands and sameness (rigidity) of ASD symptomology (Hsiao, 2018; Myers et al., 2009; Norton & Drew, 1994). This rigidity provides structure, though it is with ASD as the focus while relationships are unable to flourish with ease. Through treatment, the family was able to create more flexibility around their roles, rules, and dynamics of the family and to decenter ASD as the main organizing factor. These gains could be translated into the formation of stronger and healthier boundaries in the family system. The study also demonstrated that the decrease in rigidity had cascading effects on other domains of the family. Levels of cohesion increased as the family addressed the enmeshed boundaries that were present, and overall, the levels of satisfaction rose within the family. The family was able to see a new version of their child and

understand their needs in a radically different way that transformed their relationships. This was directly alluded to in the qualitative data received from the father. He (father) stated upon concluding the therapy, that "he felt he could understand the needs of his son more" and "wishes to connect more with him outside of talking about ASD."

There was, however, one domain of the FACES-IV measure that showed an unexpected decrease. Family Communication showed a decrease both during and after the treatment period. Generally, therapy, and especially family therapy, brings about enhanced communication, or the development of said skills, and individuals would see an increase of communication. This is especially confirmed with the qualitative data collected regarding the family's experience of therapy. If we operate under the assumption that the family generally became better in the majority of the FACES-IV subcategories, we can surmise that communication skills were enhanced, however, and the family had a chance to experience the truths of their relationships and not the reflection of the rigidity of ASD that held the family tight. In short, the family, for the first time, began conversing through a lens that was not shaped in managing ASD symptomology. It is also important to note that the family appeared to improve their scores in various domains of the FACES-IV and perhaps this allowed them to create improved boundaries with each other.

Anxiety scores on the ASC-ASD showed no improvement both in the child and parent version. While the parent version stayed readily stable, the child version showed a dramatic increase over the course of treatment. One disparity that should be noted is based on visual inspection; the parent rated their child's anxiety lower than the child rated their own anxiety. This may be an explanation as to why the levels of communication stayed relatively at the same level from mid-treatment to post-treatment. In addition to this, the advanced/intensive manner of treatment may have increased the anxiety of the child, and that, combined with no steady improvement of communication, hampered the child ability to address their anxiety within the study.

The system of care in our country is largely based on the medical model that focuses on the pathology of an individual person while ignoring the systemic impacts of said pathology on the relational environment of the individual. As stated earlier, ASD is an individual diagnosis that does impact an individual's functioning but has a broad and wide impact on family dynamics and relationships (Govind, 2018; Miranda et al., 2019). The results, while native to this single family, demonstrate that family-based treatment can provide positive outcomes for individual issues that traditionally have been treated only with the individual who has the said issue. This study calls to attention the need for more systemically based inclusive treatment for an individual within a family to address the needs of parents, siblings, and children with ASD alongside their relationships. The presence of a systemically inclined, family-based treatment option that is a part of the system of care will make it easier for parents to find relief to their heightened anxiety, parental stress, and depression (Zablotsky et al., 2013); for siblings of children with ASD to process through their isolation (Sansosti et al., 2012); and for children with ASD to develop relationships with their parents that are outside of the purvey of their diagnosis (Norton & Drew, 1994; Spain et al., 2017). While it is true that there are many family therapists who indeed treat families who have children with ASD, it is not mainstream nor public facing in mental health policy nor in MFT circles. Family therapy is versatile and can treat much more than anxiety and depression.

Limitations

While there are many findings that expand the understanding of how to provide systemic family-based treatment to families who have ASD, they should be applied with caution. Neurodiversity is just that, diverse, so the application of SFT should be done with care and be reflexive to the identity and culture of the family. In addition to applying the findings with a narrow approach, the study only lasted for 10 sessions. The family could have benefited from extended periods of therapy over a 3- to 6-month period, giving them more time to digest the work being done. The intensive application of SFT added momentum by applying intensity to the family system; however, this approach may be too time demanding for families

who have children with ASD and may explain why the level of attrition was high. This intensity may have also increased the anxiety of the children over the course of treatment. SCE comes with limitations, as do other research designs. In SCE, conclusions can be biased toward internal validity while ignoring external validity (Lenz, 2015). In addition, the interpretation of visual data is highly subjective and can promote the presence of type 1 errors (Krasny-Pacini & Evans, 2018).

Implications for the Field

Through the use of SCEs as a method of research, family therapist is able to complete and/or execute analysis of interventions on a smaller level. This ability has an impact on our field and the wellness of the families we serve. Practitioners can build a practice of demonstrating evidence to the families they serve, community behavioral health organizations, and insurance payers that systemic interventions are powerful and cause beneficial change to occur. For our field to continue moving forward, it is imperative for us to create qualitative and quantitative outcomes that can be used to shape policy and inform systems of care, from the local communities to the national level.

The use of SCEs in our field easily creates a culture of research in our field, as practitioners from all levels are easily able to design, execute, and analyze experiments that, with continued success, will help more MFTs contribute to various bodies of research knowledge.

Another implication of this study is that family therapy is able to espouse that it has the ability to produce change and treat ASD on a systemic level. While ASD itself cannot be "cured," the systemic effects of the diagnosis that impact both the individual with ASD and their family can be treated as a family. The result is closer relationships, a greater ability to navigate future problems, and an increase of qualified clinicians who are able to support this vulnerable, high needs community.

The last but most important implication this study has to offer is the understanding that change is not linear nor unidirectional. Given the rise of so many self-help books, podcasts, and standardized treatments of various diagnoses that espouse a quick steady march toward a decrease of a presenting

problem, it is important to be truthful to consumers and the general public on how the journey of change actually is. Change is difficult and often will cause a dramatic rise in the presenting problem, just like it did in this study. While we generally look at issues like anxiety, depression, and others as issues that need to process through or treated via psychotherapy and/or medication, these issues often will become worse when working through the interpersonal and relational issues. It is important to note that while they may worsen, this increase is temporary and is accompanied with an ability to manage said issue at a greater level.

Suggestions for Future Research

This study is still ongoing with the hopes to accumulate more families so that advanced statistical methods could be used. Expanding the number of families that have participated in the study will enhance the value of the research by increasing its ability to be generalized to the public and amend best practices for the treatment of ASD. Creating a larger, ongoing, and public advertisement of a clinical study that recruits families as a treatment unit will normalize for the public both the need for participation in family-based studies and the availability and viability of family therapy as a treatment option.

Conclusion

The outcomes of this study are tentative but make strong arguments for more systemic-based intervention to be researched for families with children who have ASD. Truly, the field of family therapy is young but there is great potential for more comprehensive family therapy studies.

References

Baer, J. (2002). Is family cohesion a risk or protective factor during adolescent development? *Journal of Marriage and Family*, 64(3), 668-675. https://doi.org/10.1111/j.1741-3737.2002.00668.x

Blackledge, J. T., & Hayes, S. C. (2001). Emotion regulation in acceptance and commitment therapy. *Journal of Clinical Psychology*, 57(2), 243-255. https://doi.org/10.1002/1097

Boss, P. (2016). The context and process of theory development: The story of ambiguous loss. *Journal of Family Theory & Review*, 8(3), 269-286. https://doi.org/10.1111/jftr.12152

Brockman, M., Hussain, K., Sanchez, B., & Turns, B. (2016). Managing child behavior problems in children with autism spectrum disorders: Utilizing structural and solution focused therapy with primary caregivers. *The American Journal of Family therapy*, 44(1), 1-10 https://doi.org/10.1080/01926187.2015.1099414

Central for Disease Control (April 2020). Data & Statistics on Autism Spectrum Disorder. https://www.cdc.gov/ncbddd/autism/data.html

Colapinto, J. (2019). SFT. Originally published in Arthur M Horne and Merle M. Ohlsen (eds.)., Family counseling and therapy. Itasca, Illinoi: F.E. Peacock, 1982.

Connolly, S., Grasser, K. C., Chung, W., Tabern, K., Guiou, T., Wynn, J., & Fristad, M. (2018). Multi-family psychoeducational psychotherapy (MF-PEP) for children with high functioning autism spectrum disorder. *Journal of Contemporary Psychotherapy*, 48(3), 115-121. https://doi.org/10.1007/s10879-018-9386-y

Crowe, A., & Lyness, K. P. (2014). Family functioning, coping, and distress in families with serious mental illness. *The Family Journal*, 22(2), 186-197. https://doi.org/10.1177/1066480713513552

Den Houting, J., Adams, D., Roberts, J., & Keen, D. (2018). Exploring anxiety symptomatology in school-aged autistic children using an autism-specific assessment. Research in Autism Spectrum Disorders.

Retrieved August 11, 2022, from https://nls.ldls.org.uk/welcome.html?ark:/81055/vdc_100059139278.0x00000a

Dickey, M. H. (1996). Methods for single-case experiments in family therapy. In D. H. Sprenkle & S. M. Moon (Eds.), Research methods in family therapy (pp. 264-285). The Guilford Press.

Dillenburger, K., & Keenan, M. (2009). None of the As in ABA stand for autism: Dispelling the myths. *Journal of Intellectual and Developmental Disability*, 34(2), 193-195. https://doi.org/10.1080/13668250902845244

Entringer, S. (2019). Zoloft. Retrieved from https://www.drugs.com/zoloft.html

Govind, N. (2018). Family therapy for autism spectrum disorders. *Issues in mental health nursing*. 39 (10), pp. 908-909 https://doi.org/10.1080/01612840.2018.1507597

Hall, H. R., Fruh, S., Zlomke, K., & Swingle, H. (2017). A qualitative analysis of the experiences of minority parents of children with autism spectrum disorder. *Advances in Neurodevelopmental Disorders*, 1(2), 79-88. https://doi.org/10.1007/s41252-017-0015-7

Harris, S. L., & Delmolino, L. (2002). Applied behavior analysis: Its application in the treatment of autism and related disorders in young children. *Infants & Young Children*, 14(3), 11-17. https://doi.org/10.1097/00001163-200201000-00006

Hartley, S. L., Seltzer, M. M., Barker, E. T., & Greenberg, J. S. (2011). Marital quality and families of children with developmental disabilities. In *International review of research in developmental disabilities* (Vol. 41, pp. 1-29). Academic Press. https://doi.org/10.1016/B978-0-12-386495-6.00001-1

Hilliard, R. B. (1993). Single-case methodology in psychotherapy process and outcome research. *Journal of Consulting and Clinical Psychology*, 61(3), 373. https://doi.org/10.1037/0022-006X.61.3.373

Hsiao, Y. J. (2018). Parental stress in families of children with disabilities. *Intervention in school and clinic*, 53(4), 201-205.

https://doi.org/10.1177/1053451217712956

Ingersoll, B., & Hambrick, D. Z. (2011). The relationship between the broader autism phenotype, child severity, and stress and depression in parents of children with autism spectrum disorders. *Research in Autism Spectrum Disorders*, 5(1), 337-344. https://doi.org/10.1016/j.rasd.2010.04.017

Jobski, K., Höfer, J., Hoffmann, F., & Bachmann, C. (2017). Use of psychotropic drugs in patients with autism spectrum disorders: A systematic review. *Acta Psychiatrica Scandinavica*, 135(1), 8-28. https://doi.org/10.1111/acps.12644

Kelly, A. B., Garnett, M. S., Attwood, T., & Peterson, C. (2008). Autism spectrum symptomatology in children: The impact of family and peer relationships. *Journal of abnormal child psychology*, 36(7), 1069-1081. https://doi.org/10.1007/s10802-008-9234-8

Kiami, S. R., & Goodgold, S. (2017). Support needs and coping strategies as predictors of stress level among mothers of children with autism spectrum disorder. *Autism Research and Treatment*, 2017, 8685950-8685950. https://doi.org/10.1155/2017/8685950

Kiecolt, K. J. (1994). Stress and the Decision to Change Oneself: A Theoretical Model. *Social Psychology Quarterly*, 57(1), 49-63. https://doi.org/10.2307/2786974

King, G., Baxter, D., Rosenbaum, P., Zwaigenbaum, L., & Bates, A. (2009). Belief systems of families of children with autism spectrum disorders or Down syndrome. *Focus on Autism and Other Developmental Disabilities*, 24(1), 50-64. https://doi.org/10.1177/1088357608329173

Krasny-Pacini, A., & Evans, J. (2018). Single-case experimental designs to assess intervention effectiveness in rehabilitation: A practical guide. *Annals of Physical and Rehabilitation Medicine*, 61(3), 164-179. https://doi.org/10.1016/j.rehab.2017.12.002

Kratochwill, T. R., Hitchcock, J., Horner, R. H., Levin, J. R., Odom, S. L., Rindskopf, D. M., & Shadish, W. R. (2010). Single case designs technical documentation. *What works clearinghouse*.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: a new depression diagnostic and severity measure. *Psychiatric annals*, 32(9), 509-515. https://doi.org/10.3928/0048-5713-20020901-06

Lee, N. A., Furrow, J. L., & Bradley, B. A. (2017). Emotionally focused couple therapy for parents raising a child with an autism spectrum disorder: A pilot study. *Journal of Marital and Family Therapy*, 43(4), 662-673. https://doi.org/10.1111/jmft.12225

Lenz, A. S. (2015). Using single-case research designs to demonstrate evidence for counseling practices. *Journal of Counseling & Development*, 93(4), 387-393. https://doi.org/10.1002/jcad.12036

Lopez, K., Yue, X., Magana, S., & Guzman, J. (2018). Mother's reaction to autism diagnosis: a qualitative analysis comparing Latino and white parents. *Journal of Rehabilitation*, 84(1).

Lord, C., Risi, S., DiLavore, P. S., Shulman, C., Thurm, A., & Pickles, A. (2006). Autism from 2 to 9 years of age. *Archives of General Psychiatry*, 63(6), 694-701. https://doi.org/10.1001/archpsyc.63.6.694

Lovelace, T. S., Robertson, R. E., & Tamayo, S. (2018). Experiences of African American mothers of sons with autism spectrum disorder: Lessons for improving service delivery. *Education and Training in Autism and Developmental Disabilities*, 53(1), 3-16.

McVicker, M. L. (2013). The sisters' experience of having a sibling with an autism spectrum disorder [Doctoral dissertation, Antioch University]. Antioch University Repository and Archive. https://aura.antioch.edu/etds/49

Merriam-Webster. (n.d.-a). Grief. In Merriam-Webster.com dictionary. Retrieved October 15, 2021, from https://www.merriam-webster.com/dictionary/grief

Merriam-Webster. (n.d.-b). Loss. In Merriam-Webster.com dictionary. Retrieved October 15, 2021, from https://www.merriam-webster.com/dictionary/loss

Ming, X., Sun, Y. M., Nachajon, R. V., Brimacombe, M., & Walters, A. S. (2009). Prevalence of parasomnia in autistic children with sleep disorders. *Clinical medicine*. Pediatrics, 3, CMPed-S1139. https://doi.org/10.4137/CMPed.S1139

Minuchin, S., & Fishman, H. C. (1981). Family therapy techniques. Harvard University Press.

Minuchin, S., Reiter, M. D., & Borda, C. (2021). The craft of family therapy: Challenging certainties. Routledge. https://doi.org/10.4324/9781003110996

Miranda, A., Mira, A., Berenguer, C., Rosello, B., & Baixauli, I. (2019). Parenting stress in mothers of children with autism without intellectual disability. Mediation of behavioral problems and coping strategies. *Frontiers in Psychology*, 10, 464. https://doi.org/10.3389/fpsyg.2019.00464

Moghaddam, K., Mohammadi, A. Z., Daramadi, P. S., & Afrooz, G. (2016). Effect of the family-based art therapy program on the social interactions, verbal skills and stereotypic behaviors of children with autism spectrum disorders (ASD). *Iranian journal of public health*, 45(6), 830-832.

Moh, T. A., & Magiati, I. (2012). Factors associated with parental stress and satisfaction during the process of diagnosis of children with autism spectrum disorders. *Research in Autism Spectrum Disorders*, 6(1), 293-303. https://doi.org/10.1016/j.rasd.2011.05.011

Multum, C. (2019). Haldol. Retrieved from https://www.drugs.com/mtm/haldol.html

Myers, B. J., Mackintosh, V. H., & Goin-Kochel, R. P. (2009). "My greatest joy and my greatest heart ache:" Parents' own words on how having a child in the autism spectrum has affected their lives and their families' lives. *Research in Autism Spectrum Disorders*, 3(3), 670-684. https://doi.org/10.1016/j.rasd.2009.01.004

Nealy, C. E., O'Hare, L., Powers, J. D., & Swick, D. C. (2012). The impact of autism spectrum disorders on the family: A qualitative study of mothers' perspectives. *Journal of Family Social Work*, 15(3), 187-201. https://doi.org/10.1080/10522158.2012.675624

Norton, P., & Drew, C. (1994). Autism and potential family stressors. *The American Journal of Family Therapy*, 22(1), 67-76. https://doi.org/10.1080/01926189408251298

O'Brien, M. (2007). Ambiguous loss in families of children with autism spectrum disorders. *Family Relations*, 56(2), 135-146. https://doi.org/10.1111/j.1741-3729.2007.00447.x

Olson, D. (2011). FACES IV and the circumplex model: Validation study. *Journal of marital and family therapy*, 37(1), 64-80. https://doi.org/10.1111/j.1752-0606.2009.00175.x

Pandya, S. K. (2011). Understanding brain, mind and soul: Contributions from neurology and neurosurgery. *Mens sana monographs*, 9(1), 129. https://doi.org/10.4103/0973-1229.77431

Parker, M. L., & Molteni, J. (2017). Structural family therapy and autism spectrum disorder: Bridging the disciplinary divide. *The American Journal of Family Therapy*, 45(3), 135-148. https://doi.org/10.1080/01926187.2017.1303653

Pearson, J. N., & Meadan, H. (2018). African American parents' perceptions of diagnosis and services for children with autism. *Education and Training in Autism and Developmental Disabilities*, 53(1), 17-32.

Picardi, A., Gigantesco, A., Tarolla, E., Stoppioni, V., Cerbo, R., Cremonte, M., Alessandri, G., Lega, I., & Nardocci, F. (2018). Parental Burden and its Correlates in Families of Children with Autism Spectrum Disorder: A Multicentre Study with Two Comparison Groups. *Clinical practice and epidemiology in mental health*: CP & EMH, 14, 143-176. https://doi.org/10.2174/1745017901814010143

Ramisch. (2011). Marriage and family therapists working with couples who have children with autism. *Journal of Marital and Family Therapy*, 38(2), 305-316. https://doi.org/10.1111/j.1752-0606.2010.00210.x

Ramshini, M., Hassanzadeh, S., Afrooz, G., & Hashemi Razini, H. (2018). The Effect of Family-Centered Nature Therapy on Interactions Between Parent and Child with Autism Spectrum Disorder. *Iranian Rehabilitation Journal*, 16(4), 379-386. https://doi.org/10.32598/irj.16.4.379

Rodgers, J., Wigham, S., McConachie, H., Freeston, M., Honey, E., & Parr, J. R. (2016). Development of the anxiety scale for children with autism spectrum disorder (ASC-ASD). *Autism Research*, 9(11), 1205-1215. https://doi.org/10.1002/aur.1603

Rosnati, R., & Marta, E. (1997). Parent-child relationships as a protective factor in preventing adolescents' psychosocial risk in inter-racial adoptive and non-adoptive families. *Journal of Adolescence*, 20(6), 617-631. https://doi.org/10.1006/jado.1997.0115

Sansosti, F. J., Lavik, K. B., & Sansosti, J. M. (2012). Family experiences through the autism diagnostic process. *Focus on Autism and Other Developmental Disabilities*, 27(2), 81-92. https://doi.org/10.1177/1088357612446860

Sheinkopf, S. J., & Siegel, B. (1998). Home-based behavioral treatment of young children with autism. *Journal of Autism and Developmental Disorders*, 28(1), 15-23. https://doi.org/10.1023/A:1026054701472

Sim, A., Cordier, R., Vaz, S., Parsons, R., & Falkmer, T. (2017). Relationship satisfaction and dyadic coping in couples with a child with autism spectrum disorder. *Journal of autism and developmental disorders*, 47(11), 3562-3573. https://doi.org/10.1007/s10803-017-3275-1

Spain, D., Sin, J., Linder, K. B., McMahon, J., & Happé, F. (2018). Social anxiety in autism spectrum disorder: A systematic review. *Research in Autism Spectrum Disorders*, 52, 51-68. https://doi.org/10.1016/j.rasd.2018.04.007

Sinha, S. (2019). Clozapine. Retrieved from https://www.drugs.com/clozapine.html

Smith, T., Groen, A. D., & Wynn, J. W. (2000). Randomized trial of intensive early intervention for children with pervasive developmental disorder. *American journal on mental retardation*, 105(4), 269-285. https://doi.org/10.1352/0895-8017(2000)105<0269:RTOIEI>2.0.CO;2

Smock Jordan, S., & Turns, B. (2016). Utilizing solution-focused brief therapy with families living with autism spectrum disorder. *Journal of Family Psychotherapy*, 27(3), 155-170. https://doi.org/10.1080/08975353.2016.1199766

Solomon, M., Ono, M., Timmer, S., & Goodlin-Jones, B. (2008). The effectiveness of parent-child interaction therapy for families of children on the autism spectrum. *Journal of autism and developmental disorders*, 38(9), 1767-1776. https://doi.org/10.1007/s10803-008-0567-5

Spain, D., Sin, J., Paliokosta, E., Furuta, M., Prunty, J. E., Chalder, T., ... & Happe, F. G. (2017). *Family therapy for autism spectrum disorders*. Cochrane Database of Systematic Reviews, (5). https://doi.org/10.1002/14651858.CD011894.pub2

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine*, 166(10), 1092-1097. https://doi.org/10.1001/archinte.166.10.1092

Sprenkle, D. H. (2012), Intervention Research in Couple and Family Therapy: A Methodological and Substantive Review and an Introduction to the Special Issue. *Journal of Marital and Family Therapy*, 38, 3-29. doi: 10.1111/j.1752-0606.2011. 00271.x

Su, X., Cai, R. Y., & Uljarević, M. (2018). Predictors of mental health in Chinese parents of children with autism spectrum disorder (ASD). *Journal of Autism and Developmental Disorders*, 48(4), 1159-1168. https://doi.org/10.1007/s10803-017-3364-1

Suite, D. H., La Bril, R., Primm, A., & Harrison-Ross, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: Relevance of the historical perspective in the medical and mental health treatment of people of color. *Journal of the National Medical Association*, 99(8), 879.

Thompson, G. A., McFerran, K. S., & Gold, C. (2014). Family-centered music therapy to promote social engagement in young children with severe autism spectrum disorder: A randomized controlled study. *Child: Care, Health and Development*, 40(6), 840-852. https://doi.org/10.1111/cch.12121

Thyer, B. A., & Curtis, G. C. (1983). The repeated pretest-posttest single-subject experiment: A new design for empirical clinical practice. *Journal of Behavior Therapy and Experimental Psychiatry*, 14(4), 311-315. https://doi.org/10.1016/0005-7916(83)90073-3

Turns, B., Jordan, S. S., Callahan, K., Whiting, J., & Springer, N. P. (2019). Assessing the effectiveness of solution-focused brief therapy for couples raising a child with autism: A pilot clinical outcome study. *Journal of Couple & Relationship Therapy*, 18(3), 257-279. https://doi.org/10.1080/15332691.2019.1571975

Turns, B., Eddy, B. P., & Jordan, S. S. (2016). Working with siblings of children with autism: A solution-focused approach. *Australian and New Zealand Journal of Family Therapy*, 37(4), 558-571. https://doi.org/10.1002/anzf.1183

Van Bourgondien, M. E., & Schopler, E. (1996). Intervention for adults with autism. *Journal of Rehabilitation*, 62(1), 65.

Van Schoors, M., De Paepe, A. L., Lemiere, J., Morez, A., Norga, K., Lambrecht, K., ... & Verhofstadt, L. L. (2019). Family adjustment when facing pediatric cancer: the role of parental psychological flexibility, Dyadic coping, and network support. *Frontiers in Psychology*, 10, 2740. https://doi.org/10.3389/fpsyg.2019.02740

Van Steensel, F. J., & Heeman, E. J. (2017). Anxiety levels in children with autism spectrum disorder: A meta-analysis. *Journal of Child and Family Studies*, 26(7), 1753-1767. https://doi.org/10.1007/s10826-017-0687-7

Veatch, O. J., Sutcliffe, J. S., Warren, Z. E., Keenan, B. T., Potter, M. H., & Malow, B. A. (2017). Shorter sleep duration is associated with social impairment and comorbidities in ASD. *Autism Research*, 10(7), 1221-1238. https://doi.org/10.1002/aur.1765

Velasco de Parra, M. L., Dávila de Cortazar, S., & Covarrubias-Espinoza, G. (1983). The adaptive pattern of families with a leukemic child. *Family Systems Medicine*, 1(4), 30. https://doi.org/10.1037/h0089639

Vetere, A. (2001). SFT. *Child Psychology and Psychiatry Review*, 6(3), 133-139. https://doi.org/10.1017/S1360641701002672

Virues-Ortega, J., Julio, F. M., & Pastor-Barriuso, R. (2013). The TEACCH program for children and adults with autism: A meta-analysis of intervention studies. *Clinical Psychology Review*, 33(8), 940-953. https://doi.org/10.1016/j.cpr.2013.07.005

Wagner, D. V., Borduin, C. M., Mazurek, M. O., Kanne, S. M., & Dopp, A. R. (2019). Multisystemic therapy for disruptive behavior problems in youths with autism spectrum disorder: Results from a small randomized clinical trial. *Evidence-Based Practice in Child and Adolescent Mental Health*, 4(1), 42-54. https://doi.org/10.1080/23794925.2018.1560237

White, S. W., Oswald, D., Ollendick, T., & Scahill, L. (2009). Anxiety in children and adolescents with autism spectrum disorders. *Clinical Psychology Review*, 29(3), 216-229. https://doi.org/10.1016/j.cpr.2009.01.003

Young, L. J., & Barrett, C. E. (2015). Can oxytocin treat autism? *Science*, 347(6224), 825-826. https://doi.org/10.1126/science.aaa8120

Zablotsky, B., Bradshaw, C. P., & Stuart, E. A. (2013). The association between mental health, stress, and coping supports in mothers of children with autism spectrum disorders. *Journal of Autism and Developmental Disorders*, 43(6), 1380-1393. https://doi.org/10.1007/s10803-012-1693-7

APPENDIX A: AUTHORIZATION AND RELEASE

ANTIOCH UNIVERSITY
AUTHORIZATION AND RELEASE
Video and Audio Recordings for Use in Training Videos

Participant Name: _____

I am a participant in NAME, a study conducted by the Antioch University Seattle's NAME Program. I understand that as part of the study, therapy sessions of participants (including myself) will be recorded via video and/or audio ("Recordings"). I acknowledge that the Recording may include my participation, likeness, voice or image. I authorize Antioch University, its successors or agents to store the recordings securely in connection with NAME and to use the Recordings obtained during my participation to create clinical training videos for psychology students and practitioners.

I understand and agree that the Recordings and the Materials will become the property of Antioch and will not be returned. I irrevocably authorize Antioch to edit, publish, or broadcast the Materials for any purpose by means of any media, both inside and outside Antioch University.

I waive any right to privacy associated with the Recordings and any right to approve the finished product in which it appears. I hereby hold harmless, release and forever discharge Antioch from all claims, demands, and causes of action which I or any other persons acting on my behalf or on behalf of my heirs or my estate may have by reason of this authorization.

_____I am 18 years of age and am competent to contract in my own name. I have read this release before signing below and I fully understand it.

_____Participant is under 18 years of age, and I certify that I am the parent or guardian of the Participant with legal authority to provide consent on behalf of the Participant. I have read this release before signing below and I fully understand it.

_____ _____
Signature Date

_____ _____
Printed Name Phone

_____ _____
Address City, State, Zip Code

_____
Relationship to Participant

APPENDIX B: INFORMED CONSENT FORM

Informed Consent: CFT ASD Study

This agreement is intended as a supplement to the general consent to counseling agreement for the purposes of participating in a research study. Ages of consent will follow the same guidelines as consent for treatment. Children ages 13 and above will sign separate consent forms. Families with children 12 and younger need only one consent form per family. Your signature indicates agreement with its terms and conditions.

1. **Process of Research**
    a. **What you can expect-** This is a research study that is aimed at treating children with autism spectrum disorder (ASD) in a family-based setting using Structural Family therapy and assess/evaluate the usefulness of family-based interventions in treating ASD. You will be entitled to 8 - 10 free therapy sessions with a student therapist under the supervision of a Licensed Marriage & Family Therapist (LMFT) and will complete 5 questionnaires. Each week, you will have (2) 90-minute sessions. The first 45-minutes will be dedicated to the entire family (family based) and the remaining 45-minutes will be dedicated to parental time (individual support and psychoeducation). It is expected that everyone in the home will be involved in the family-based sessions consistently. Families will complete the 5 questionnaires (GAD-7, PHQ-9, ASC-ASD, FACES and 2 open ended questions) three times during the treatment process. These questionnaires are aimed at assessing levels of anxiety, depression, family communication, family cohesion and family adaptability. If any questions arise during the course of this study, participants can reach the Principal Researcher, Anthony Pennant (REDACTED) or Shawn Fitzgerald, AUNE Provost at (REDACTED)
2. **Confidentiality of Data**
    a. **What you can expect-** Your personal data (session notes) will be kept in a confidential and HIPAA compliant Electronic Health Record system known as CarePath. Your questionnaire answers and session recordings will be kept on a HIPAA compliant folder in Google Drive. Only the Principal

Researcher (Anthony Pennant), his dissertation chair (Kevin Lyness) and student therapists will have access to this data. Participants are able at any time able to request a copy of their clinical case files for review.

3. Benefits and potential risks of this study

a. **What you can expect-** This study is offering FREE family-based therapy to families who have children with ASD. Often services associated with the presence of ASD are geared individually toward the child and support for parents are separate (parental support groups). This study will give the opportunity for families to address anxiety and depression openly via support with mental health therapists. Possible risks are feelings of distress during treatment due to addressing issue that stem from ASD symptomology. There may be an increase in anxiety, depression or other emotions during this process.

4. Voluntary Nature of this study

a. **What you can expect-** Participation in this study is voluntary and you will have the ability to withdraw at any time without penalty. If families do withdraw from the research portion of the study, this will cease the treatment given to the family. Should you desire to withdraw from the study, simply email (REDACTED) to confirm with the Principal Investigator, Anthony Pennant that you would like to withdraw immediately. Likewise, if there are concerns regarding the nature of the study, it is within your ability to reach out to Anthony Pennant at the same above email address to schedule a call to discuss any issues.

APPENDIX C: ADVANCE THEORY SYLLABUS

ANTIOCH UNIVERSITY
SEATTLE

COUN 5730
Adv. Theory: SFT with Families & ASD

Credits:	3
Prerequisites:	None
Meeting Times:	Wednesdays, 5:00 pm - 8:00 pm
Meeting Dates:	July 7th – September 8th, 2021
Quarter:	Summer 2021
Location:	AUS Main Campus
Address:	2400 3rd Ave #200, Seattle, WA 98121
Instructor:	Anthony Pennant, LMFT
Contact Info:	(REDACTED)
Teaching Liaison:	Jennifer Sampson
Contact Info:	(REDACTED)

Course Description

The purpose of this course is to facilitate the development of competencies in understanding advanced systemic theories and models in couple and family therapy.

CFT Course Competency Information

CFT Competency Domain: This course is within the Couple & Family Systems Domain (Domain #1) and primarily addresses the following program goals:

- PG 2: Graduate students who demonstrate a relational and systemic philosophy and ethics in their clinical practice.
- PG 3: Graduate students who integrate multiculturally attuned clinical knowledge, skills, and research that is adaptable to work with client populations of varying social locations and contexts.
- PG 4: Graduate students who promote inclusion, respect for diversity, anti-discrimination, and social responsibility from a culturally responsive perspective.

CFT Student Learning Outcomes (SLOs). Out of the three SLOs, the following SLOs will be addressed in this course:

- SLO-1: Students will integrate and apply systemic and multiculturally attuned clinical knowledge, skills, research, and evidence-based practice that is adaptable to work with client populations of varying social locations and contexts.

- SLO-2: Students will effectively use couple, relational, and family systems theories to inform systemic case conceptualizations and treatment plans in their clinical work.

Course Objectives. More specifically, by successfully completing the requirements for this course, students will be able to:

- Understand a family systems theory of human communication and connection
- Apply family systems concepts in the analysis of family relationship problems
- Understand the utility of a specific family therapy model in assessing and treating clients
- Use skills and interventions from a specific family therapy model to conduct family therapy with a client system
- Analyze clinical strengths and weaknesses through live supervision and receive feedback surrounding the model's application with a client system

Demonstration of Competency: Students should complete *Chapter 2: Emerging Clinical Integration & Theory of Change, Part III: How Your Clinical Approach Informs Your Treatment Process* of their capstone portfolio (see Capstone Project below) and include this document in their final portfolio after necessary revisions.

Capstone Project

Chapter 2: Emerging Clinical Integration & Theory of Change -- Part III: How Your Clinical Approach Informs Your Treatment Process

Purpose: In part I you considered your perspective and personal preferences that inform theory selection, and in part II you considered client factors that inform theory selection and adaptation. For part III you are narrowing your focus to specify your theoretically integrative process of therapy from the beginning to the end of treatment. Your answers to this section should be consistent given the CFT theories and clinical concepts you have previously discussed in parts I and II. *You are strongly encouraged to use examples from your clinical work to illustrate your responses.*

You must discuss your clinical integration approach as it pertains to the following:

1. Assessment and diagnosis
    a) *Example guiding question: Describe your approach for assessment and providing diagnoses for the client system. How is your approach to assessment and diagnosis informed by your chosen CFT theories/models?*
2. Biopsychosocial issues
    a) *Example guiding questions: Describe your approach for attending to multicultural differences in clients. How do your chosen CFT theories/models best represent this to you? What strategies do you use and how do they work?*
3. Treatment planning and goal setting
    a) *Example guiding questions: Describe your approach for creating a treatment plan. How do you set goals for client work? Who has input into the goals? How do your chosen CFT theories/models inform this process?*
4. Treatment process and interventions
    a) Example guiding questions: *When do you begin intervening with a client? How do you select which interventions to use considering your chosen CFT theories/models? Which approaches to intervention do you find the most beneficial?*
5. Client change process
    a) The therapeutic relationship and the therapist's role in change

i. *Example guiding questions: How does the therapeutic relationship influence client change? How does the Person of the Therapist (self-of-the-therapist) interact with client work and progress?*

b) The role of extra-therapeutic factors in change (i.e., things that happen outside of therapy)

i. *Example guiding questions: What outside factors may influence client change? How does this occur? How do you attend to these in session?*

c) The role of your chosen CFT theories/models in change

i. *Example guiding questions: What aspects of your chosen theories or models influence client change? How does this occur?*

6. Termination processes, including the assessment of therapy outcomes

a) *Example guiding questions: How do you determine if goals were met? Is this based in symptom reduction, elimination, or something else? How do your chosen CFT theories/models help you determine when goals have been met?*

Course Requirements

To obtain credit for this course, all students must meet minimum attendance, scholarship, and competency standards.

Attendance. Students are expected to attend all scheduled classes. Credits may be denied for failure to attend classes. Failure to attend at least 90% of the class meeting time, or at least 27 clock hours, will result in no credit for the course unless appropriate makeup work is completed. If a student falls below the 90% standard of attendance, it is the student's responsibility to arrange for appropriate makeup work with the instructor. No makeup work will be permitted, and no credit will be granted in those cases where 20% or more of the total class meeting time has been missed. If you are not at the first-class meeting and you do not contact the instructor, you risk being dropped from the class roster.

Conduct. Students are expected to be treated and to treat others with respect. Failure to do so may result in suspension, dismissal, or exclusion from class.

Plagiarism. Plagiarism is defined as the presentation of an idea or a product as one's own, when that idea or product is derived from another source and presented without credit to the original source. "Idea or product" includes not only written work but also artworks, images, performances or ideas expressed orally or via any electronic or other medium.

Communication Protocol. All students must have access to computer technology. AUS maintains computer access in the AUS Library on the third floor and the study center on the second floor. E-mail accounts and addresses are assigned for all Antioch Seattle students. Students are required to check their e-mail accounts at least weekly and are responsible for being aware of information posted as official announcements and through their programs. To comply with students' record confidentiality and security requirements, official e-mail communication with Antioch Seattle, including e-mail between students and instructors, should originate from and be conducted within the Antioch University Seattle e-mail system.
Special Note: I reserve the right to ignore emails which are not professional.

Incompletes. If a student does not satisfactorily complete the assigned work in a course by the end of the term, he or she will be granted No Credit. If a student is unable to complete the work due to extraordinary extending circumstances, he or she should discuss the matter with the instructor and, if approved, the instructor can assign an incomplete (INC) and set a deadline of thirty (30) days for required submission of all remaining assignments. The

incomplete will be calculated in the same way as No Credit is when determining the student's academic standing. Upon satisfactory completion of the INC, it will no longer count against the student's academic standing. If the work is not completed by the deadline and an assessment has not been submitted, a No Credit (NC) will be assigned, not subject to change. To earn credit for a course deemed No Credit or permanently incomplete, the student must reenroll in and repay for the course. Incomplete contracts are not available to non-matriculated or visiting students. Upon withdrawal from Antioch, outstanding incomplete courses are converted to NC (No Credit). An NC is permanent and not subject to change. Students must complete all course and degree requirements prior to or on the last day of classes of a term to be eligible to graduate that term.

Scholarship. All written papers must conform to the School of Applied Psychology's style guidelines for writing academic papers and to APA's writing standards for graduate level scholarship. Failure to adhere to these standards of scholarly writing will result in the automatic return of a paper. No participant will be permitted more than one opportunity to re-write a paper that fails to meet these academic standards. In addition, no re-written final papers will be accepted beyond the end of the eleventh week of the quarter.

Competence. All students are expected to demonstrate Required Competency in order to receive credit for the course. The different levels of competence that will be assessed for this course are as follows:

1. *Below Competency*—failed to meet minimum graduate-level competency in terms of the course attendance, scholarship, and performance standards.
2. *Required Competency*—met minimum graduate-level competency in terms of the course attendance, scholarship, and performance standards.
3. *Intermediate Competency*—achieved Required Competency plus demonstrated mastery of the identified course knowledge and/or skills areas.

As a part of preparatory curriculum, *Advanced Competency* is not possible for this course. Advanced Competency is only possible during internship.

CFT Narrative Assessment Professional Core Competencies

COURSE REQUIREMENTS	BELOW REQUIRED COMPETENCY *Applicable to all Courses*	REQUIRED COMPETENCY *Applicable to all Courses*	INTERMEDIATE COMPETENCY *Applicable to all Courses*	ADVANCED COMPETENCY *Applicable to Internship Case Consultation Courses Only*

Professionalism Adheres to the ethical guidelines of AAMFT/ACA. Behaves in a professional manner towards supervisors, instructors, peers, and clients (e.g., emotional regulation). Is respectful and appreciative to the culture of colleagues and is able to effectively collaborate with others	❑ Student has exhibited behavior that is not aligned with counseling profession ethical standards ❑ Student struggles to accept and integrate feedback ❑ Student struggles to maintain appropriate boundaries with peers/ instructors (e.g., inappropriate, disrespectful communication, emotional reactivity) ❑ Student struggles with tracking themselves and self-awareness ❑ Student has difficulty expressing frustration, confusion, or struggle without attacking, devaluing, or exhibiting hostility ❑ Student has been given feedback and appears unwilling to change/revise behavior	❑ Student has exhibited behavior that is aligned with counseling profession ethical standards ❑ Student accepts and integrates feedback ❑ Student maintains appropriate boundaries with peers/ instructors (e.g., appropriate, respectful communication without emotional reactivity) ❑ Student tracks themselves and self-awareness ❑ Student appropriately expresses frustration, confusion, or struggles without attacking, devaluing, or exhibiting hostility ❑ Student is in the process of expanding in interpersonal effectiveness as a clinician-in-training (e.g., empathy, responsibility, reasonable judgment)	❑ Student has exhibited behavior that is aligned with or exceeds counseling profession ethical standards ❑ Student seeks, accepts, and integrates feedback ❑ Student maintains appropriate boundaries with peers/ instructors while modeling a flexible disposition ❑ Student excels at self-awareness and applying that knowledge to their interactions with others ❑ Student uses their evolving skills to successfully express frustration, confusion, or struggle without attacking, devaluing, or exhibiting hostility ❑ Student continues to hone their process of interpersonal effectiveness as a clinician-in-training (e.g., patience, respect, empathy, responsibility, reasonable judgment)	❑ Student has exhibited behavior that is aligned with and exceeds counseling profession ethical standards ❑ Student proactively seeks, accepts, and integrates feedback ❑ Student maintains appropriate boundaries with peers/ instructors while modeling a flexible, open, and humble disposition ❑ Student excels at self-awareness and applying that knowledge to their clinical work/interactions with others ❑ Student uses advanced skills to communicate struggle without attacking, devaluing, or exhibiting hostility ❑ Student has an advanced understanding of their interpersonal effectiveness in all aspects of their work as a clinician-in-training (e.g., patience, respect, empathy, responsibility, reasonable judgment, tolerates ambiguity, manages personal well-being)
Reflective Practice Demonstrates capacity to engage in self-analysis, flexibility in thinking, sitting with abstract concepts and complexity. Exhibit's ability to take responsibility for behavior, choices, and mistakes	❑ Student struggles to use feedback to increase self-knowledge and self-awareness ❑ Student is unable to make connections between areas of growth and potential harm to client/peers ❑ Student in process of developing more awareness of privilege and how that may impact effectiveness with clients ❑ Student exhibits defensiveness ❑ Student struggles to submit assignments/written products that balance appropriate self-disclosure and professionalism ❑ Student struggles with identifying what is appropriate to share in class or assignments ❑ Student struggles with realistic expectations of peers or instructors	❑ Student uses feedback to increase self-awareness and purposeful reflection ❑ Student makes connections between areas of growth and potential harm to client/peers ❑ Student has appropriate awareness of privilege and how that may impact effectiveness with clients ❑ Student is self-reflective, non-defensive, and open to discussion and feedback ❑ Student submits assignments that explore finding a balance between appropriate self-disclosure and professionalism connected to the role of counselor ❑ Student has realistic expectations of peers/instructors	❑ Student uses feedback to increase self-awareness and purposeful reflection taking, responsibility for personal/professional choices ❑ Student makes connections between areas of growth and potential harm to client/peers ❑ Student has appropriate awareness of privilege and how that may impact effectiveness with clients ❑ Student is self-reflective and non-defensive conveying an open stance and welcomes feedback ❑ Student submits assignments that explore appropriate self-disclosure, professionalism, reflection that is connected to the role of counselor ❑ Student has insightful and realistic expectations of self, peers, and instructors	❑ Student uses feedback to increase self-awareness and purposeful reflection, taking responsibility for personal/professional choices ❑ Student makes insightful connections between areas of growth and potential harm to client/peers and adjusts their work with others accordingly ❑ Student has appropriate awareness of privilege and how that may impact effectiveness with clients ❑ Student is self-reflective and non-defensive conveying an open stance, welcomes and incorporates feedback ❑ Student submits assignments that clearly articulate an advanced understanding of appropriate self-disclosure, professionalism, and reflection that is connected to the role of counselor ❑ Student excels in realistic personal and professional expectations of self, peers, and instructors

Applied Critical Thinking Recognizes multiple sides of an issues, tolerate ambiguity, accept situations which require flexibility in thinking and creative solutions	❑ Student struggles to see beyond personal experience and develop skills related to counseling profession ❑ Student struggles to understand course material in a way that allows for depth and application to work with clients ❑ Students assignments are underdeveloped	❑ Student is able to see beyond personal experience and is developing skills related to counseling profession ❑ Student understands course material in a way that allows for depth and application to work with clients ❑ Students assignments are developmentally appropriate and flexible, offering creative perspectives of key concepts related to the course	❑ Student is informed by personal experience, using clinical skills to balance intellectual curiosity and critical thinking as it relates to the counseling profession ❑ Student understands course material in a way that allows for depth, abstract thinking, ambiguity, and new knowledge of application to work with clients ❑ Students assignments are organized, and developmentally sound, offering creative perspectives of key theoretical concepts	❑ Student is informed by personal experience, integrating intellectual curiosity/advanced critical thinking skills related to the counseling profession ❑ Student has an advanced understanding of course material and its multiple issues, allowing for depth, abstract thinking, flexibility ambiguity, and ongoing application to their work with clients ❑ Student's assignments are well-organized, developmentally advanced, offering creative key theoretical concepts and solutions
Diversity and Social Justice Demonstrates awareness, knowledge, and skills of both self and other, in relation to working with individuals, groups and communities from various cultural backgrounds and identities. Works to dismantle systems of marginalization, domination, oppression, and consciously resists engaging in microaggressions	❑ Student struggles to demonstrate evidence of growth and awareness in relation to working with groups and communities from various cultural backgrounds and identities ❑ Student has engaged in subtle or overt messages lacking in cultural awareness that humiliate, offend, or invalidate a person verbally or nonverbally, intentionally or unintentionally, with little or no effort to acknowledge the behavior ❑ Student struggles to integrate feedback and change behavior ❑ Student struggles with awareness and how this might impact effectiveness as a counselor or therapist ❑ Student struggles to communicate about issues related to culture with peers and instructors ❑ Student has engaged in behaviors that minimize importance of developing advocacy skills in the context of marginalized populations and cultures	❑ Student demonstrates evidence of growth and awareness regarding work with groups/communities from various cultural backgrounds & identities ❑ Student has increased their knowledge of perceived micro-aggressions regarding self or others ❑ Student works to integrate feedback and if needed, changes behavior ❑ Student has an awareness of personal experiences and/or potential biases and how these might impact effectiveness as a counselor ❑ Student works to communicate about issues related to culture with peers and instructors ❑ Student engages in behaviors that support the importance of developing advocacy skills, as applicable, in the context of marginalized populations and cultures	❑ Student shows significant growth/awareness working with groups/communities from various cultural backgrounds identities ❑ Student has a clear understanding of perceived micro-aggressions regarding self or others ❑ Student integrates feedback and if needed, changes behavior ❑ Student has an awareness of personal experiences and/or potential biases and how these might impact effectiveness as a counselor ❑ Student appropriately communicates issues related to culture with peer and instructors ❑ Student proactively engages in behaviors that actively exhibit the importance of developing advocacy skills and demonstrates an understanding of social justice, anti-racism, anti-oppression, as applicable, in the context of marginalized populations and cultures	❑ Student shows significant growth and an advanced awareness regarding work with groups or communities from various cultural backgrounds & identities ❑ Student excels in understanding perceived micro-aggressions regarding self or others ❑ Student effectively integrates feedback and if needed, changes behavior ❑ Student has an advanced awareness of personal experiences and/or potential biases and how these might impact effectiveness as a counselor ❑ Student uses advanced skills to communicate issues related to culture with peers and instructors ❑ Student proactively engages in advanced behaviors that actively exhibit the importance of developing advocacy skills and demonstrates an understanding of social justice, anti-racism, anti-oppression, as applicable, in the context of marginalized populations and cultures

Written Communication Writes clearly, professionally and reflectively; integrates personal and academic material Presents ideas and information in an organized format Demonstrates Master's level technical writing skills and APA style Student does not engage in plagiarism of any type	❑ Student's writing skills require improvement (e.g., grammar, punctuation, editing, sentence structure) ❑ Student requires increased knowledge of APA standards and application to written work ❑ Student's timeliness of completed/submitted assignments needs attention ❑ Student demonstrates an understanding of course material in class discussions/activities, but struggles to communicate same understanding in written assignments ❑ Student plagiarized parts, some, or all of written work	❑ Student meets writing skills (e.g., grammar, punctuation, editing, sentence structure) ❑ Student incorporates acceptable use of APA standards and application to written work ❑ Student completes/submits written assignments on time ❑ Student demonstrates congruence with course material in class and in written assignments	❑ Student meets or exceeds writing skills (e.g., grammar, punctuation, editing, sentence structure) ❑ Student incorporates acceptable APA standards as evidenced by their professional application to written work ❑ Student completes/submits written assignments in an efficient and timely manner ❑ Student demonstrates congruence with course material, integrating a balance of personal reflection and academic material in class and written assignments	❑ Student exceeds writing skills (e.g., grammar, punctuation, editing, sentence structure) ❑ Student incorporates advanced APA standards as evidenced by their professional application to written work ❑ Student excels at completing/submitting written assignments in an efficient and timely manner ❑ Student demonstrates an advanced understanding of the course material by integrating a balance of personal reflection, insight, and academically sound material in class and written assignments
Overall Competency Performance Demonstrated graduate level work regarding Student Learning Objectives and Course Assignments	❑ Student has been unable to achieve required competency in the following areas: Professionalism, Reflective Practice, Applied Critical Thinking, Diversity & Social Justice, and Written Communication – NO Credit for the course can be given. ❑ Professional Development Plan (PDP) for remedial support to be created by Student & Advisor	❑ Student has successfully met required competency in the following areas: Professionalism, Reflective Practice, Applied Critical Thinking, Diversity & Social Justice, and Written Communication. ❑ Student has fulfilled course requirements, showcased originality and required competence ❑ Student's contribution to the course has successfully influenced their overall learning	❑ Student has successfully met intermediate competency in the following areas: Professionalism, Reflective Practice, Applied Critical Thinking, Diversity & Social Justice, and Written Communication. ❑ Student has fulfilled course requirements, showcasing originality and intermediate competence ❑ Student's contribution to the course has positively influenced their classmates and instructor's overall learning	❑ Student has successfully met advanced competency in the following areas: Professionalism, Reflective Practice, Applied Critical Thinking, Diversity & Social Justice, and Written Communication. ❑ Student has fulfilled course requirements, showcasing originality and advanced competence ❑ Student's contribution to the course has significantly influenced their classmates and Instructor's overall learning

Required Reading

Minuchin, S., Reiter, M. D., & Borda, C. (2021). *The craft of family therapy: Challenging certainties*. Routledge. ISBN 978-0-415-70812-8

Additional reading in Sakai

Learning Experiences

- Students will apply Structural Family Therapy to a simulated case family. Students are expected to be prepared to engage with the theory in such a way that allows them to increase their familiarity and eventual mastering of techniques and interventions.
- Students will be able to recognize and analyze SFT interventions and apply them to various systemic problems.
- Students will be able to deepen their understanding of autism spectrum disorder, it's impact on the individual and family functioning and the use of Critical Disability Theory in applying systemic models with individuals and families with disabilities.
- Students will be able to utilize Structural Maps. These Maps will directly support conceptualization of presenting problems through a lens of SFT.

Assignments

Students will have two major papers for this class: **Model Exploration of Structural Family Therapy** and **Session Reflection**.

The Model Exploration of Structural Family Therapy Paper- Students will refine and synthesize their understanding of SFT and their theory of change. Students will touch on all interventions of SFT and apply the use of this model to a diverse population of their choice. Students should be able to explain in depth what each intervention is and its application in the therapeutic process of seeing a family. Lastly, while students have the ability to choose a diverse population of their choice, they should justify this decision with at least two theoretical or historical tenets of SFT. The paper should be 10- 12 pages doubled-spaced paper utilizing APA formatting, proper grammar and spelling.

Session Reflection Paper- Students will have the opportunity to conduct at least one therapy session utilizing SFT in the Simulated experience with a family. In this paper, students will reflect on their experience using SFT but also answer the following:

1. What are the strengths and weaknesses in using SFT with families who have a child with ASD?
2. How does Critical Disability affect the clinicians' stance and understanding SFT?
3. How did the family change and/or adapt when hierarchy, boundaries and structure were changed?
4. How does this model affect your ability to address racism, sexism, ableism and oppression in the therapy room?
5. How did you identify any Person of the Therapist issues during the session?
6. How did you manage any Person of the Therapist issues during the session?
7. What assessment techniques were used? How do you know they were effective?
8. What were your favorite techniques and how did you use this "in your own voice"?
9. In what ways did this model challenge your theory of change?

The paper should be 8-10 pages double spaced. Proper grammar, spelling and APA format apply.

Class Schedule

The specific class schedule, topics, assignments, and their due dates for this course are as follows:

Course Schedule

Week	Date	Topic(s)	Readings/Assignments *NOTE: Readings and assignments in this column should be completed and/or submitted **before** class.*
Week 1		**Course Introduction** ▪ Schedule & Syllabus ▪ Orientation to Sakai ▪ Sign up for Simulated Lab Weeks ▪ Review Articles **The Social Justice of Structural Family Therapy** ▪ History of the Model and initial families served **Person of the Therapist** ▪ Model overview and application ▪ Applicability of model to modern day practice	**Assignments due:** • None **Readings**
Week 2		**Model Exploration** ▪ Joining and Accommodating ▪ Enactments ▪ Structural Mapping **Assessment via Structural Family Therapy** ○ ***Minuchin 4-step process***	**Assignments due:** • None **Readings** **Craft: Chapters 1-6** **Week 2 Readings**
Week 3		**Model Exploration Cont'd** ▪ Highlighting and Modifying Interactions ▪ Boundary Making ▪ Unbalancing ▪ Challenging Unproductive Assumptions	**Assignments due:** • None **Readings** **Craft: Chapters 7-9** **Week 3 Readings**

Week 4		**Autism Spectrum Disorder, Disability and Critical Disability Theory (Cont'd)** ▪ Presenting Behaviors ▪ Severity Level ▪ Diagnosis & Assessment ▪ Family Impact ▪ How does SFT fit here?	**Assignments due:** ▪ **None** **Readings** **Craft: Chapters 10-13**

Week 5		**Circumplex Model Overview and Usefulness**	**Assignments due:** • Model Exploration of Structural Family Therapy
Week 6		**Sim Lab**	**Journal Entry Due**
Week 7		**Sim Lab**	**Journal Entry Due**
Week 8		**Sim Lab**	**Journal Entry Due**
Week 9		**Sim Lab**	**Journal Entry Due**
Week 10		**Sim Lab**	**Journal Entry Due** **Assignments due:** Final Paper
Week 11		**NO CLASS**	

Please note: The above course schedule, content, and assignments are subject to change at the discretion of the instructor.

The above schedule, assignments, due dates, and content are subject to change at the discretion of the instructor. In addition, please be available during week 11 of the quarter to accommodate any required changes in the above schedule.

Antioch University Policies

Antioch University is committed to building a vibrant and inclusive educational environment that promotes learning and the free exchange of ideas. Our academic and learning communities are based upon the expectation that their members uphold the shared goal of academic excellence through honesty, integrity, and pride in one's own academic efforts and respectful treatment of the academic efforts of others. All students are expected to comply with Antioch University policies, including the Title IX Sexual Harassment and Sexual Violence Policy, Student Academic Integrity Policy, and the Student Conduct Policy. Academic, student, and other university policies are available online: http://aura.antioch.edu/au_policies/ Questions about policies may be directed to Erica Holmes, Associate Provost, at (REDACTED) or (REDACTED).

Reasonable Accommodation for Students with Disabilities. Antioch University is committed to providing reasonable accommodations to qualified students with disabilities in accordance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 2008. Students with disabilities may contact the Disability Support Services office to initiate the process and request accommodations that will enable them to have an equal opportunity to benefit from and participate in the institution's programs and services. Students are encouraged to do this as early in the term as possible, since reasonable accommodations are not retroactive. The Disability Support Services office is available to address questions regarding reasonable accommodations at any point in the term. For more information, please contact Jill Haddaway, Disability Support Services Coordinator: (REDACTED) or (REDACTED).

Library Services and Research Support. The AUS Library is here to serve you throughout your academic career. On our physical shelves, you will find books carefully selected to help you in your academic pursuits. In addition, you will also find journals, masters' theses, dissertations, and videos/DVDs. The AUS Library provides computers including PCs and Macs, a printer/copier, and scanners available for you to use. You may also bring your laptop and connect to the campus wireless system. To search the library catalog and beyond, please see the AUS Library web page, http://www.antiochseattle.edu/library. Both the catalog and our extensive research databases may be searched from off campus. Please call the AUS Library at (REDACTED) if you need information on how to access the databases. The library teaches workshops throughout the year that are designed to help you in your research. Students may also make an appointment with the librarian for individual research help. Call or email Beverly Stuart, Library Director, at (REDACTED) or (REDACTED).

Writing Support at Antioch University. Much of your learning is writing intensive, and you will write in a variety of genres, from critical reflections to more formal research papers. Writing for an academic audience can also require one to gain new understandings about style and format. All students are encouraged to seek writing support for their courses throughout their career at Antioch. Students at AUS have multiple venues for free writing support:

- Writing Lab (room 323 Library/CTL): The Writing Lab offers free peer-based writing consultations (schedule directly online at https://antiochctl.mywconline; call (REDACTED); or email

(REDACTED)) and drop-in hours. They also conduct workshops and maintain resources for successful writing at AUS. Writing Lab consultants are graduate students in various programs at AUS and thus have deep understanding of the types of writing done by students here. Check their website for future workshops on topics related to academic writing.

- The Virtual Writing Center (VWC): The VWC is located at antioch.edu/vwc and allows busy AU students to get quality peer-based feedback of their writing within 48 hours. Live conversations with peer e-tutors may also be arranged by emailing (REDACTED).
- The Writers' Exchange (WEX) was developed at Antioch University in direct response to the increase demand of graduate students' need for specialized editing support that exceeded the free peer-editing available at the Virtual Writing Center. If you're working on your thesis or dissertation, or just want professional writing support, visit WEX at wex.antioch.edu. All WEX editors are professionals who have been vetted for their range of editing experience and the breadth of their expertise. Our fees are competitive and further discounted for the entire AU community.