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Integrative Families and Systems Treatment: A Middle Path Towards Integrating Common and Specific Factors in Evidence Based Family Therapy

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Abstract

A moderate common factors approach is proposed as a synthesis or middle path to integrate common and specific factors in evidence based approaches to high-risk youth and families. The debate in family therapy between common and specific factors camps is reviewed and followed by suggestions from the literature for synthesis and creative flexibility in manual development. A preliminary integrative model termed I-FAST is offered as one option in developing and testing a moderate common factors approach. Such a model might then be studied in eventual clinical trials with other well developed evidence based protocols to further address the common versus specific factor debate. Implications for further research and practice are offered.

Integrative Families and Systems Treatment:

A Middle Path towards Integrating Common and Specific Factors

in Evidence Based Family Therapy

Thesis—antithesis—synthesis; the wisdom of dialectics and Taoism is in integration. Wisdom is in finding synthesis or in following the middle path.

In 2004, a lively interchange entered the family therapy literature through the pages of this journal (cf. Sexton & Ridley, 2004; Sexton, Ridley, & Kleiner 2004; Sprenkle & Blow, 2004a, 2004b). The interchange echoed a now decades-old debate found in the broader psychotherapy literature. The questions at stake focused on the factors that explain why treatment works. These are questions such as: "How may we best define the effective elements of therapy?" and "Given that treatment is effective, is the effect due to a range of factors common to all effective treatment (or so called "common factors") or to the application of a set of procedures defined by a set of protocols (often referred to as "specific factors")?" Both sides presented convincing arguments and evidence. Unlike the debate in the larger psychotherapy literature, proponents on both sides of the family therapy debate made an effort to move toward a more centrist position. Sexton and Ridley (2004) acknowledged that common factors are obvious and important parts of any effective MFT and that an either/or stance is detrimental to the field. For their part, Sprenkle and Blow (2004) made clear that they do not favor the positions more radical proponents of the common factors such as Duncan, & Miller (2000), and Wampold, (2001). Instead, they view models as vehicles through which common factors operate. With this in mind, they referred to their position as a moderated common factors approach.

Despite the attempt at rapprochement, the differences between these two camps were significant enough that the interchange was left unresolved. Both sides called for further discussion however; there has been only indirect exchange in the family literature on this important subject since then. A recent work by Sprenkle, Davis and Lebow (2009), however, promises to reawaken this discussion.

The purpose of this paper is to take this discussion to the next level. We will offer an evolving approach which we have developed over the past seven years. The importance of this evolving protocol to the question of common and specific factors is that it fits the description of what Sprenkle and Blow (2004), and more recently, Sprenkle, Davis and Lebow (2009) refer to as a moderated common factors approach. Moreover, we refer to our model as a meta-model that uses the common factors and a perspective on the general process of change to organize treatment and train behavioral health specialists. Our approach, namely Integrative Family and Systems Treatment (I-FAST), is being used and tested with high-risk youth and families in a home based intervention format. This treatment population comes from community mental health settings and shares similarities with populations served by empirically supported treatment models such as FFT, and MST.

Our intent is to offer I-FAST as a modest option for how one might build and test a moderate common factors model against a range of alternate efficacious models developed for the same population. We will start by discussing the key elements of a moderated common factors approach. We will then review the components of I-FAST, show how the components match the literature, and how the approach strives to maximize the effects of each element. We will then reference preliminary research results, discuss the developmental stage of I-FAST as a manualized approach, and end with some thoughts about the advantages of adopting a treatment model based on common factors.

A Middle Path: Moderated Common Factors

What Sprenkle and Blow (2004a, 2004b) and Sprenkle, Davis and Lebow (2009) have argued is that the elements of therapy which contribute the most variance to outcome in successful relational treatment can be accounted for by what they term a moderate set of common factors. Citing meta-analyses and related conclusions from the psychotherapy literature (cf. Frank & Frank, 1991; Hubble, Duncan & Miller, 1999; Lambert, 1992; Lambert & Ogles, 2004; Smith & Glass, 1979; Wampold, 2001), they suggest a simple division of common factors into *client factors*, *therapist effects*, the *therapeutic relationship*, *expectancy effects* and such nonspecific treatment variables described by Karasu (1986) as

behavioral regulation (changing the doing of the problem), *emotional experiencing* (changing the emotions around the problem), and *cognitive mastery* (changing the viewing of the problem).

These common factors are derived from individual therapy research and are consistent with the findings of Castonguay and Beutler (2006) in their work, *Principles of Therapeutic Change That Work* (the findings of a joint taskforce reviewing the literature across treatments for dysphoric, anxiety, personality, and substance abuse problems). They conclude that all effective treatments are delivered by therapists in *relationships* that include a strong and sustained *working alliance*, *cohesion* within a group being treated, *empathy*, *collaboration* and *goal consensus*, *positive regard*, *congruence*, *repair of alliance ruptures*, *self-disclosure*, and *feedback*, including positive relational interpretations. Regarding *technique* factors, they conclude that positive change across all effective approaches is provided by therapists who provide a *structured treatment rationale* and who *remain focused* in the application of his or her interventions, and who offer a skillful *balance of directive and non-directive interventions*. They suggest that effective therapy may require therapists to address both interpersonal and intrapersonal aspects of clients functioning and that a *therapist who includes others in treatment* with an identified client (as do relational and family and systems therapists) may be more effective in treatment and relapse-prevention. Time-limited therapy can be beneficial and intense therapy in "massed" treatment sessions is frequently helpful and often required for some problems. Finally, they conclude that therapy is likely to be beneficial if therapists facilitate change in clients' *cognitions*, *behavioral, emotional* or *physiological responses*, facilitate *client self-expression*, enhance clients' ability to *accept, tolerate and often fully experience their emotions*, and *learn new options* to control their emotions. These conclusions are strikingly similar to the above noted variables laid out by Sprenkle, Davis and Lebow (2009).

While these constructs are rather broad it is important to note that they represent a convergence of empirically derived common principles of therapeutic change. They combine the full range of common factors, delivered within a focused and coherent therapeutic rationale agreed upon between clients and therapists, employing a set of procedures targeting cognitive, behavioral, emotional and physiological changes in a frequently intense and time-limited format. With these factors from the literature on

individual psychotherapy in mind, Sprenkle and his colleagues (1999) added common factors that uniquely apply to marriage and family therapy. These include *a relational conceptualization, an expanded direct treatment system*, *an expanded direct treatment alliance*, *allegiance*, *coherence*, and *dysfunctional pattern disruption*. The concept of relational conceptualizations reflects the emphasis that MFT's place on the relational aspects of problems. Consequently, MFT's are inclined to expand the direct treatment system which in turn changes the nature of the treatment alliance as it expands into a configuration that is more than dyadic. Allegiance, coherence, and disruption of dysfunctional patterns are constructs that require further discussion.

Allegiance, Coherence, Pattern Disruption

Wampold (2001), and Luborsky et al. (1999; 2002), among others, have made a compelling case that allegiance to a model being employed and/or studied often accounts for much more of the outcome variance in psychotherapy than does the model used itself. This has often been the focus of extensive critiques of the research supporting some of the evidence based treatment protocols that have been studied most often by advocates of these approaches (cf. Littell, 2005; 2008, for a general review of allegiance effects in MST research, as well as other evidence-based approaches to children and youth). The clinical practice implication of this perspective, however, suggests that clinicians who believe in their approach will be more effective (Blow, Sprenkle & Davis, 2007; Sexton, 2007; Simon, 2006; Sprenkle & Blow, 2007). The element of organization and coherence gained from using a given therapy model, however, is possibly an even more salient argument for a moderate common factors approach. Sprenkle and his colleagues (2009) argue that:

> We believe that one explanation for the potency of empirically validated models resides in their being very organized and coherent. The people who practice these therapies have a clear roadmap of the dysfunction they are addressing, the place where they want clients to go, and how to get there. This very organization and coherence impacts other variables we have discussed, such as the therapist's confidence and the credibility of the therapist and the model for the client. (p.58)

This position is very close to Jerome Frank's (1991) elements of all effective therapies and Snyder, Michael and Cheavens (1999) operational definition and review of hope. Hope, Frank's target for combating demoralization, is described by Snyder and his colleagues as being achieved when a therapist *provides a rationale* that explains the nature of a problem, implies an organized pathway to resolve that problem, and enlists clients' investment in following that pathway toward resolution. This is further supported by the literature reviewed by Tryon and Winograd (2002) on goal consensus and collaboration, one aspect of the working alliance as defined by Bordin (1979). There is overwhelming evidence that clients and therapists who are mutually invested in an agreed upon rationale for treatment and who have consensus upon clear goals and collaborate to achieve them within a focused structure have increased prospects of success. There is considerable evidence that offering a credible treatment that matches clients' expectations is strongly associated with engagement in the tasks and goals of the therapeutic alliance and highly correlated with success in treatment.

While, once again this may not be surprising, it has powerful implications for research and practice. As this moderate common factors approach suggests, common factors are potentiated through the use of coherent and organized models. For example, clinical trial research studying a well organized and coherent model practiced by therapists with allegiance to that model compared with "treatment as usual" may result in support for each model studied as a major byproduct of the studied model's organization and coherence as much as it is a product of the model studied alone. As Sprenkle and his colleagues (2009) have put it, "…organization and coherence can be a mediator—that explains why change occurs. They could also be a moderator, in that a given treatment may work only under the condition that it is well organized and coherent" (p. 59). Thus strong fidelity to a model in clinical trials may say as much about the effects of a well organized and coherent approach on the hope generated in clients and therapists, their investment and collaborative goal consensus and engagement in the procedures practiced as it does about the specific techniques of the model itself. So, having a meta-model to guide practice and using specific rationales and related organized procedures may be a critical component of most effective therapy.

The last added common factor suggested to apply uniquely to marriage and family therapy is *disrupting dysfunctional relational patterns.* Sprenkle and colleagues cite the work of Davis and Piercy, (2007a, 2007b) that suggests that a factor common to all systemic models is the disruption of *interactional cycles*. Sprenkle and colleagues (2009) indicate that historically relational therapists have viewed their work as breaking up dysfunctional patterns that keep families or larger systems stuck. They argue further that while the evidence for this common factor is indirect, all of the best empirically validated relational approaches to therapy utilize approaches designed to disrupt problem patterns of interaction. Disrupting problem patterns (pattern shift) that result in resolution of the presenting problem has been referred to as *second-order change* (Watzlawick, Weakland & Fisch, 1974) which Fraser and Solovey (2007) have asserted is the "golden thread" running through *all* evidence-based therapies.*What Makes These Factors Moderate?*

What makes Sprenkle and colleagues view of the common factors moderate is that they repeatedly stress that the common versus specific factors discussion does not need to be couched in either/or terms. They further argue that they are actually supporters of efficacious treatment models as well as supporters of clinical trials conducted comparing efficacious treatments for a given treatment population (Sprenkle & Blow, 2004a, 2004 b; Sprenkle, Davis & Lebow, 2009). Clearly, not all treatments do work, and those found less effective should be abandoned. They note and admire the range of specific treatment approaches in individual therapy for focused problems, as well as the range of well-supported approaches in the family therapy domain to treat, for example, externalizing and delinquent youth and families like the Functional Family Therapy (FFT) approach supported by Sexton (Sexton & Alexander, 2003). At the same time they point out that there are commonalities amongst specific approaches. More specifically they note the explicit emphasis of the first phase of the FFT model which engages clients and elicits motivation through support, acceptance, agreement on goals and reframing as a critical element of the model's effectiveness. A common factor emphasis is explicitly embedded in this useful approach. Furthermore, regarding intense family approaches for acting-out and substance use problems in youth, they agree with Kazdin (2002) who notes that there is evident overlap among the four

or five evidence supported treatments for acting out juveniles, given that they all appear to be equally effective. There are clearly common elements shared across these equally efficacious approaches, many if not most of them enhanced by common factors. In sum, they value both the role of therapy models in the organization and coherence of treatment and the common factors that are evident when treatment is effective. It is a matter of both/and versus either/or.

Evolving a moderate model

After decades of practice, consulting, teaching and scholarship in family and systemic therapy, it had become evident to members of our research team that there are more similarities among effective treatments than there are differences. Several members of the team had long written on integration, on systemically integrative approaches to crisis intervention, and on integrating and adapting systemic approaches to a wide range of practice settings. Flexible adaptation and integration had become a core factor of all team members' work. Furthermore, while team members had collaborated with and been mentored by such charismatic leaders as Jay Haley from the strategic family therapy approach, Paul Watzlawick and John Weakland from the MRI brief therapy approach, and Steve DeShazer and Inso Kim Berg of the solution focused brief family therapy approach, the convergence in the work of all team members had become apparent. Strength based empowering systemic work was not only the focus of the team members' work with client systems, but also of consulting work with individual therapists and agencies. Two team members had also finished work on a book following what was termed the "golden thread" of second-order change or pattern shift across all evidence-based psychotherapy (Fraser & Solovey, 2007). Clearly, the tracking of first-order vicious cycle problem patterns across all systems and facilitating problem pattern shifts or second-order change was equally present in all team members' practice. Such pattern shift was equally apparent as a key element across all evidence based approaches to high risk adolescents such as Functional Family Therapy (FFT) (Sexton & Alexander, 2003), Multisystemic Family Therapy (MST) (Schoenwald & Henggler, 2005.), Brief Strategic Family

Therapy (BSFT) (Szapocznik, Robbins, Mitrani, Santisteban, Hervis & Williams, 2002), and Multidimensional Family Therapy (MDFT) (Liddle, 2002) approaches.

Evidence based "best practices" had become such an emphasis in public mental health and juvenile justice systems that the state in which the research team is based had begun offering seed grants for mental health agencies to purchase training, consultation and certification in such approaches as FFT, MST, BSFT, or MDFT. It was unclear how the State or agencies were to choose which "best practice" to purchase, but purchasing and implementing one of them had become a priority. It was becoming equally clear, however, that many agencies who had purchased and tried to implement these models had also dropped them when the funding ran out or when the practice models were perceived to be too narrow in focus, inflexible, or not able to fit with the general practice of the therapists, agency, clients or community involved (Massatti, Sweeney, Panzano & Roth, 2008). This was the practical initiative for the research team to propose, develop, implement and study an alternative and more flexibly adaptive model. The model proposed would build upon evidence based common factors; client, therapist, and agency empowerment and adaptability; and multisystem involvement; *all organized around the key coherent focus of intervening in vicious cycles of multisystem problem patterns and initiating pattern shift or second-order change*.

The team was able to arrange for access to two large rural mental health agencies, and the state's department of mental health supported the developmental study through a generous grant. To keep the model adaptable with real world agency practice, the target of training was upon case managers doing in-home intervention as opposed to masters or doctoral level office based practitioners alone. To balance the effect of specific models being used by team members doing the training and consultation, one team member operating out of a foundation of Haley's strategic model did the training and consultation at half of the mental health center sites involved, and another team member operating out of a base of the MRI and solution focused models did the training and consultation at the other half. A core protocol was developed, however, which was taught and practiced across all sites, and fidelity checks were conducted

across sites to determine consistency in the model's application. Two team members taking the lead on the research came from a strength based solution focused view, developing fidelity check lists, conducting regular site visits and training independent raters to do video and audio tape reviews to assure fidelity to the moderated model. That evolved model was finally called an Integrated Families and Systems or I-FAST approach. The elements of this approach and their foundations follow. *This model is a both/and, moderated approach, in that it explicitly focuses upon implementing common factors while offering a coherent and organized protocol with the tracking of vicious problem cycle patterns and the initiation of pattern shift or second-order change as its key organizing factor.*

The I-FAST model

Integrative Family and Systems Treatment (I-FAST) is a home-based treatment model that has been developed and implemented within the community mental health system. I-FAST assumes that: (1) Effective treatment of a child or adolescent with a severe emotional or behavioral problem necessitates treatment of the family system, (2) Families are resilient and have strengths and resources that can be used in building solutions and achieving client change, (3) Effective treatment must include coordination and collaboration among the diverse organizations providing services to the child and the family (4) It is important to intervene no more than is necessary to get a small but necessary and lasting shift in the interactional patterns between the child and parents and the other systems involved with them, and (4) Effective treatment is built upon training and retaining excellent staff with expertise in providing home-based family services.

The treatment model is built around three major *common factors* identified in the evidence-based literature on family treatment with at-risk children, youth and families. These common factors are: (1) develop and maintain a *positive therapeutic alliance* with the family members; (2) intervene to bring about *second-order change* in problematic patterns by having the parents be the ones to solve the presenting problem (*pattern change*); and (3) work with the various systems involved with the family so they collaborate in supporting the parents as the ones solving the presenting problem (*systems collaboration*).

In the debate on common and specific factors Sexton and Ridley (2004) complain that in some cases common factors are the outcomes of change processes. They go on to say that an outcome is the result of some activity initiated by the therapist and family/couple. Additionally, a change mechanism is a therapeutic activity initiated by a therapist, aimed at increasing the probability of a specific outcome. Ironically, this is our view of how common factors work. From the perspective of I-FAST, treatment is comprised of multiple embedded change processes that are designed to achieve specific outcomes. For example, goal consensus is a label given to the outcome of a specific process. The evidence on psychotherapy outcome indicates that the *process* of obtaining goal consensus is a necessary component in the overall process of change. It is also sufficiently powerful *to produce change on its own* in selected cases. In other words, for example, coming to a clear goal consensus with clients may create the kind of epiphany for all involved such that the change begins right then. Another way of putting this is that goal consensus may be both a general and specific intervention in and of itself. We argue that common factors are general in the sense that they are embedded in all effective treatment. At the same time they are also specific because all effective family treatments include methods for achieving these process goals within their frameworks. In many cases, goal consensus is *both* a common factor and a specific intervention. *Alliance-building activities,* for example, are both a *process* as well as pathway toward a desired *outcome*.

Therapeutic Alliance

The literature has repeatedly described the important role of the therapeutic alliance in facilitating positive outcomes in working with clients and families (Asay & Lambert, 1999). Based on Bordin's work (1979), I-FAST views the therapeutic alliance as consisting of three dimensions: (1) Development of bonds (Johnson, Wright & Ketring, 2002); (2) Agreement on goals (Bordin, 1979; Johnson, et al., 2002; Pinsof, 1994); and (3) Agreement on tasks (Johnson, et al., 2002). Furthermore, alliance needs to be obtained not only within the family system members, but also with the multiple agencies and organizations usually involved with these high-risk adolescents (Diamond, Liddle,

Wintersteen, et al., 2006; Hogue, Dauber, Stambaugh, et al., 2006; Knobloch-Fedders, Pinsoff, & Mann, 2004, 2007; Thompson, Bender Lantry & Flynn, 2007; Robbins, Liddle, Turner, Dakof , Alexander & Kogan, 2006; Shelf, Diamond, Diamond & Liddle, 2005). In addition, I-FAST is influenced by the strengths perspective and solution-focused therapy in viewing a focus on a family's strengths, competencies, and resources as important in successfully developing a therapeutic alliance and effecting positive change (outcomes) with clients (Berg, 1994; Lee, Sebold, & Uken, 2003). A related issue on alliance is that the I-FAST model treats the issue of who to include in treatment as a strategic decision and it is flexible on this. Alliances are flexibly built with all members and agencies of what might be called the "problem-generated system," or all of those defining the distressed youth and family as a problem and who are attempting to do something about it (Anderson, Goolishian & Winderman, 1986). Exactly who to see in treatment and who to ally with is flexibly decided upon from one case to the next. There are no set groupings or members who must or must not be seen from one case to another. This flexibility differs from several other evidence informed protocols and allows I-FAST to integrate several family therapy approaches that deal with this issue differently.

Pattern Change (Second-Order Change)

There is a growing convergence upon the concept of *pattern change* as a major factor that is a target of change shared by all relational treatments (Davis & Piercy, 2007a, 2007b; Sprenkle, Davis & Lebow, 2009). The kind of pattern change that we assert is operative across all effective treatments and not just family and systems approaches is what we term *the general process of change* model and focuses on first- and second-order change (Fraser & Solovey, 2007). This model incorporates the effects of socially constructed constraints on the definition of problems and their resolution which then channel the solution patterns of all involved with the problem at hand. While some solutions successfully resolve the perceived problem, others actually become the problem, fueling escalating vicious cycles of first-order change. In these instances the goal of change is a "change of change" in the multi-system solution patterns, or second-order change. This general process of change model should not be confused with the very useful meta-model of the process of change described by Prochaska, (1999) that describes

interventions appropriate to different stages of change with clients. It should also be distinguished from the wide array of change processes now being synthesized by meta-analyses and literature reviews across effective treatments for different problems (cf. Castonguay & Beutler, 2006). The general process of change model is viewed as a meta-model that incorporates and is informed by these evidence supported constructs.

In the struggle to translate evidence based or efficacious treatments to clinical practice domains there is also growing convergence upon developing manuals or protocols that are organized and coherent and yet still offer therapists the option for flexibility and clinical creativity. Beutler (2002), in response to concerns over the perceived "rigidity" of manual guided treatments, cites the, "…critical need to balance flexibility with structure, therapist creativity with treatment fidelity, and therapist control with generalizability…" (p.435). He stresses the need for treatment manuals that allow therapists flexibility in choosing how problems are to be conceptualized and deciding what procedures are to be used. Moving to more *evidence informed* selection of treatment frames and rationale will likely offer therapists with much greater leeway in using their own creativity and judgments. Referring to the tension between adherence and strict fidelity to manuals versus more flexible clinical practice, Addis and Walz (2002) suggest that: "It is possible that optimal outcomes will result from effectively balancing the dialectic between adherence and flexibility…" (p. 422). Steven Hayes (2002), developer of the widely popular Acceptance and Commitment Therapy (ACT) model, calls for manuals that are humble, simple and short. Such manuals should focus upon a few most important steps and effective clinical principles, general methods and simple keystone practices to guide therapists in effective clinical practice. Westen (2002) supports this more flexible practice of integrating effective treatments within clinical practice calling it *empirically informed* psychotherapy. We similarly view our evolving moderate common factors model as *evidence informed practice*, emphasizing common factors through the organizing meta-model of *the general process of change.*

As laid out in the work, *Second-Order Change in Psychotherapy: The Golden Thread that Unifies Effective Therapies* (Fraser & Solovey, 2007), this general process of change model is one meta-

model that can be used to integrate and apply a wide range of demonstrated evidence supported treatment approaches. *This is the meta-model used to provide organization and coherence for the I-FAST approach* while allowing great flexibility for therapists in choosing fitting therapeutic rationales, frames, and related interventions for each different set of multiple systems around each different problem adolescent, and fitting best with the skills and perspectives of the therapist doing the intervention.

Influenced by a systems perspective and the concept of feedback mechanisms (Hoffman, 1981; Keeney & Ross, 1985), I-FAST postulates that a change in the problem-maintaining pattern at the family interactional level is required for the change process (*second-order change*) (Fisch, Weakland, & Segal, 1982; Fraser & Solovey, 2007; Greene, 2002; Grove & Haley, 1993). Approaches to change behavioral patterns include but are not limited to a strategic view of using behavioral prescriptions for disrupting the problem-maintaining patterns and changing the family system (Fisch, Weakland & Segal, 1982; Grove & Haley, 1993; Haley, 1990; Nardone & Watzlawick, 1993), a solution-focused view of identifying and amplifying patterns in which the problem does not occur, is less frequent, or the problem is being handled in a more satisfactory manner (solution-building) (De Jong & Berg, 2007; Lee et al., 2003), or a structural view of changing family relational patterns and organization primarily by interventions made in the session with the family (Minuchin & Fishman, 1981). Regardless of the approach to creating pattern change in the family, I-FAST emphasizes that the practitioner intervenes in a way that empowers the parents to be the ones to successfully solve the child or adolescent's presenting problem(s) rather than the professionals. *If one were to posit any key "active ingredient" or organizing factor in addition to the power of the common factors being used, it might best be viewed as the emphasis of this model on pattern shift that often results in second-order change.*

Systems Collaboration

Many, if not most, of the families with a child or adolescent with a severe emotional or behavioral problem are concurrently involved with practitioners from several different agencies, i.e., mental health, social services, juvenile courts, schools, psychiatric hospitals and so on. When practitioners from different agencies are involved with these family systems a new system is temporarily created which

can help or hinder the resolution of the presenting problem (Anderson, Goolishian & Winderman, 1988; Boyd-Franklin & Bry, 2000; Schwartzman, 1985). Practitioners from these agencies can involve themselves with families in ways that "can sometimes perpetuate the very problems they were intended to solve" (Imber-Black, 1991, p. 584). Frequently, practitioners from these agencies get involved with these families by restraining the out-of-control child and placing her or him outside the home in various settings such as residential care, foster care, juvenile detention, or a hospital. In those situations, the family's interactional pattern with the problematic child may not change for several reasons two of which may be: (1) the goal of the intervention is safety and not changes in how parents deal with the problems the child has, and (2) the child is settled down by professionals outside the family rather than empowering the parents as the primary solver of the child's problem. For home-based services to be a cost-effective alternative to out-of-home placement home-based staff must be able to influence practitioners from the institutions in charge of placing children outside the home and empower parents to be the ones to regain control over their out-of-control child (Imber-Black, 1988, 1991). Consequently, collaboration between and among practitioners from the different systems involved with these families is integral to achieving positive outcomes (Liddle, 2002; Henggler, Mihalic, Rone, Thomas & Timmons-Mitchell, 2001). The perspective of I-FAST is that just as interventions should focus on changing the problem maintaining patterns within families, they should also focus on changing the problem maintaining interactions between practitioners from outside agencies and the family. The approach is often looking to create pattern shift that results in second-order change as much within agencies (both those external to the delivering agency as well as the agency delivering services) as with the families in question.

To make these changes I-FAST practitioners need to develop and maintain collaborative relationships with these other practitioners similar to how they do with the families in treatment (Fraenkel, 2006; Koch, Egbert & Coeling, 2005; Madsen, 2007; Selekman, 2005; Sells, 1998). Such relationships can and should be developed and maintained whether or not there are formal agreements between the mental health system and the other involved systems (Darlington & Feeney, 2008; Horwath & Morrison, 2007).

A final special emphasis of the I-FAST approach to systems collaboration is the idea that both therapists and agencies need to be empowered to adapt and to "own" this meta-model. *Another major defining characteristic of this moderated common factor approach is the attention it pays to respecting the unique characteristics and strengths of the case managers, therapists and agencies choosing to follow the approach.* The success of the I-FAST approach may be most critically linked to how it is adapted to and by interveners and agencies to match their strengths, motivations, values, and world view (Grove, 2010). Particular attention is paid to both how the model fits with agencies and what is needed from the agencies to sustain the intervention model after our departure. *Creating positive belief and enthusiasm in the ultimate effectiveness of the approach as the interveners' and agency's own approach is most likely to support and sustain the effectiveness of the model itself.*

Walking the Middle Path

An important reason for the development of I-FAST was to determine if a coherent treatment protocol could be built around the common factors. If a moderate common factors protocol might be developed that offers the promise of effectiveness in intervening with high risk youth and families (as do the several other excellent EST approaches to this population like FFT, MST, BSFT, and MDFT) then such an approach might be able to be used in future clinical trials in comparison with these other efficacious approaches to test a wide range of questions. Just one of these questions might be whether the moderate common factors protocol can match the effectiveness of the alternate protocols. If not, then there certainly must be some truth to the utility of implementing these organized treatment interventions and remaining strictly faithful to these already well-established protocols. If the outcomes prove to be comparable or even favor the moderate common factors protocol, then this will raise a wide range of questions regarding the promise of using such a broader and more flexible approach.

Our approach to developing this working model has been guided by Carroll and her colleagues' three-stage model of manual development (Carroll & Nuro, 2002; Carroll & Roundsville, 2003, 2007: Roundsville, Carroll, & Onken, 2001). As they suggest, stage one (described as *stage 1a*, *therapy development/manual writing*) need only require a theoretical rationale for the approach, identification of a

treatment population to be addressed, specifying measures to be used in initial evaluation of the treatment and, (with the potential availability of other efficacious treatments for the population) a description of how the new treatment differs from and may improve upon currently available treatments. The end product of this phase is a provisional or working version of a flexible treatment manual specifying treatment rationales and procedures. They recommend developing such approaches at this phase in *close collaboration with clinicians in clinical practice working directly with the target clients and problems to be addressed* so as to benefit from developmental feedback from and relevance to the applied setting. This is exactly what we have done. This phase is then followed by a *stage 1b or pilot trial* stage with the nearly final version of the new treatment. This phase looks at patient acceptance of the new treatment, the ability to recruit and retain significant numbers of the target population, a look at the feasibility of delivering the proposed treatment with the proposed types of therapists, patients and treatment settings, clinically significant patient improvement in at least one important outcome domain, and outcomes which are large enough to hold promise for further therapist training and clinical trials in stage two. They emphasize developing therapist-friendly manuals that anticipate real-world problems, offer troubleshooting guidelines, attend to the basics of forming alliances with clear bonds and goals before emphasizing unique tasks, that offer clear choice points for choosing direction with interventions, and finally which build in flexibility for the practicing clinician. These elements have been at the core of I-FAST model development. Stage two, then focuses on further refinement of the manual to serve as a basis for a randomized controlled trial. This stage includes further training and supervision of therapists to conduct the treatment, review of session tapes, and further analysis of process and outcome data from pilot work to refine the protocol. Stage three involves broader implementation and dissemination of the approach. Our current model has now progressed through phases 1a & b.

A Pilot Trial

Thus far, the I-FAST model has been developed, taught, implemented and researched in a preliminary pilot study. While the details of the study are available elsewhere (Lee, et al., 2009), the results have been promising. The pilot used a one-group pre- and post-test design with a six-month

follow-up to explore the effectiveness of I-FAST in treating families with children at risk of out-of home placement and receiving home-based treatment. The outcomes indicated that I-FAST treatment lead to improved functioning, reduced problem severity in the child, reduction in out of-home placement of the child, improved family functioning, increased parental competency in addressing their child's problems, and increased family participation in the treatment process. An additional positive larger systems qualitative result of this several-year training and study pilot was that, when the multiple agencies within the counties involved in the pilot were offered additional state and federal funds to apply to any project they wished, they uniformly applied those funds to adding additional I-FAST therapists. Since the end of the pilot, there have been numerous other agencies trained in the model. Some of these groups are now functioning on their own with trained internal supervisors who maintain the general structure of the model while being empowered in the process of adapting it to their own agency, therapist and client needs.

Advantages of I-FAST

Because the I-FAST model is early in its stage of development it is too soon to claim advantages over more established frameworks. At the same time, feedback provided by agencies where I-FAST has been implemented suggests that certain facets of the model are quite attractive. Another important reason that I-FAST was developed was to overcome some of the limitations associated with manualized treatment protocols. Protocols that target specific treatment populations are often difficult to implement in community mental health centers where clients have diverse problems. Concerns shared with us by agencies that have adopted I-FAST have also been reflected in national surveys of clinicians. Summarizing the results of national surveys of practicing clinicians attitudes towards psychotherapy treatment manuals, Addis and his colleagues (Addis & Krasnow, 2000; Addis, Wade & Hatgis, 1999; Addis & Waltz, 2002) list hurdles such as constraints on practitioner time, length and cost of training; limits on practitioner and clinical administrator buy-in to the EST rationale; and constraints on clinical services inconsistent with many treatment protocols, among other hurdles.

More recently, a study of "de-adoption," which examined why organizations choose not to sustain innovative mental health practices or EST's, has found a number of converging difficulties

(Massatti, Sweeney, Panzano & Roth, 2008). Not surprisingly, their study confirmed what others have also noted including staff problems in understanding the approach; administrative resistance to change; lack of stakeholder commitment; low site readiness to implement the approach; inadequate staff training and fidelity; insufficient staff access to technical supervisory support; inadequate external referral patterns and support; the view that the approach was being externally imposed; and above all, the lack of sustained financial support for what is often rather expensive training and ongoing fidelity consultation.

In order to address these concerns, I-FAST expands its systems perspective to the agency level by integrating the program within the larger administrative structure of the agency. Agencies adopting I-FAST are encouraged to adapt the model to fit with its unique characteristics. This includes experience that agency staff already have with providing family therapy to at-risk youth and their families. Since we teach a meta-perspective, great respect is accorded to what clinicians and supervisors already know. We believe that this enhances personal investment and ownership of the model, which in turn increases commitment to adoption. The general structure of the I-FAST approach appears to provide the needed organization and coherence within which the model may be adapted to the specific strengths and unique character of different agencies, therapists, client populations and community agencies applying the approach.

To move toward agency integration, I-FAST seeks to initiate a parallel process of empowerment at the client level, agency level, and inter-agency level. The programmatic structure of home-based treatment using I-FAST involves administrative and clinical support to the home-based treatment staff. With respect to administrative support, the home-based staff is assigned no more than 10 to 12 cases at one time. In addition, Emergency Services and other agencies involved with these families provide services to them at nights and on weekends. A crisis plan is developed with each family receiving I-FAST and this plan is readily available in the client records and emergency service staff members are informed of the plan. This approach frees up case managers from continuous on-call responsibility. Continuous on-call can be a contributing factor to burnout and result in turnover of competent community-based staff.

The services of a consultant are used to provide ongoing clinical support and training to home-based treatment teams. Through the process of consulting with the team on their cases, the consultant teaches home-based staff and other professionals, including center directors and supervisors, how to use core I-FAST treatment components and how to generalize treatment principles to other cases. The consultant and agency supervisory roles are clearly delineated. The consultant teaches and suggests treatment approaches. Responsibility for the treatment is clearly owned by the agency. This means that agency supervisors can overrule an I-FAST consultant suggested intervention if there is concern that it does not fit within the agency or communities' unique culture.

Because clinical consultation is offered to the home-based staff as well as other treatment professionals at the agency, a goal of the approach is for the I-FAST principles to become an integral part of the other services the agency provides. When families terminate from intense community-based services they frequently continue to receive treatment from other professionals employed at the agency thus providing continuity of care. An expectation is that eventually key staff at the agency will develop enough expertise in I-FAST home-based treatment that outside consultants will no longer be needed. The ultimate training goal is to influence the treatment culture within the agency instead of creating a special area of knowledge or expertise that is known only by a limited number of specialists in one program at the agency.

Advantages of a Middle Path

In conclusion, I-FAST continues to solidify and evolve as a unified protocol that provides coherence and structure to the training of clinicians who treat at-risk families. Therapists are empowered to use creativity and clinical experience to develop literature informed interventions while agencies are empowered to develop ownership for the model. Our group is now refining the protocol to initiate the next stage, or stage II of manual development and preliminary clinical trials to compare this moderate common factors approach with other evidence supported and manualized approaches with this high-risk population of youth and families.

A moderate common factors model such as the one just described and others like it may hold promise of a wide range of benefits. Conceptually, positive clinical trial results may offer further support for the potency of teaching and emphasizing common factors within an organized approach. It may also offer conceptual support to using a broad organizing meta-model to offer a guiding structure for goals and interventions, while allowing for greater flexibility for therapists in applying a wider range of therapeutic rationales and procedures in their interventions. Methodologically speaking, the availability of such moderate common factors protocols might provide a tool for studying a wide number of questions regarding therapist, client, interaction and intervention factors. Practically speaking, the success of a structured yet flexible moderate common factors approach may go far in overcoming many of the current objections of clinicians and their agencies to the perceived rigidity and therapist disempowerment of many of the current evidence based protocols. Agencies adopting such moderate common factors models are encouraged to adapt them to the unique strengths and characteristics of their own agency, therapists, clients, and community. Such personal investment in, and ownership of this sort of model may increase the proportion of agencies adopting and sustaining such evidence informed practices. One possible indicator of a model's success is the extent that frontline agencies are satisfied with the cost-effectiveness, flexibility, and degree of fit with the values of the agencies and their staff. Thus far, based on this indicator of success IFAST appears to be promising.

These goals of developing and implementing a moderate common factors approach are all easier said then done. The I-FAST model described here is simply one modest proposal. Developing such models should not be taken in any way as attempts to depreciate the outstanding models already available as evidence based approaches to high-risk youth and families, as well as other target populations. Developing alternate moderate common factors models is only being proposed as a set of first steps along a promising middle path to answer a set of pressing questions in theory, research and practice. Exactly where that path will led, and how difficult it will be to travel is yet to be seen. Still, the wisdom of synthesis and the middle path remains compelling.

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