1.5 ECOLOGICALLY BASED FAMILY THERAPY FOR ADOLESCENTS WHO HAVE LEFT HOME

Laura Cully, Qiong Wu, & Natasha Slesnick

CONTEXT & EVIDENCE

Adolescents who access shelters have usually experienced high levels of family conflict and a lack of family support (Ferguson, 2009; Tyler, 2006). Their home environments are often characterized by instability, including a lack of parental protection, chaos in the household, and substance use among family members. Moreover, these adolescents often experience maltreatment, including verbal, physical, and sexual abuse, as well as emotional neglect and rejection (Ferguson, 2009). Studies report that 50% to 83% of youth who are homeless have experienced physical abuse and 17% to 39% have experienced sexual abuse (Edidin, Ganim, Hunter, & Karnik, 2012; Gwadz, Nish, Leonard, & Strauss, 2007). The problems youth face at home are often motivators for leaving home and a barrier to returning. This means that including the family in intervention efforts can optimize positive outcomes.

A family systems approach to intervention understands individual problems as symptoms of the larger interactional problems among family members (Karabanow & Clement, 2004). Although adolescents who have left home report high rates of anxiety and mood disorders and substance use (Pollio, Thompson, Tobias, Reid, & Spitznagel, 2006; Slesnick & Prestopnik, 2005; Slesnick, Dashora, Letcher, Erdem, & Serovich, 2009), very few actively seek formal treatment. Barber, Fonagy, Fulth, Simulinas, and Yates (2005) reported that 22% of adolescents seeking services at shelters accessed mental health services and 6% accessed substance use treatment services. The primary goal of these shelters is to reintegrate adolescents into their homes (U.S. Department of Health and Human Services, 1974). The majority of youth who seek these services return home (Peled, Spiro, & Dekel, 2005; Thompson, Pollio, & Bitner, 2000; Thompson, Safyer, & Pollio, 2001). Family therapy has shown promise in improving family interaction patterns that underlie family conflict (Zhang & Slesnick, 2017) and in easing the transition of adolescents back into the home (Slesnick & Prestopnik, 2005). Studies also indicate significant improvements in individual problem behaviours such as substance use and mental health issues as a result of family therapy (Carr, 2013; Meis et al., 2013).

Integrating family therapy interventions into the services of shelters can facilitate the mission of shelters to reintegrate and support family reunification, as well as ameliorating ongoing individual struggles. One family-based intervention called Support to Reunite, Involve and Value Each Other (STRIVE; Milburn, 2007) was tested with youth who were newly homeless, with the goals of reuniting families and reducing HIV risk behaviours. Compared with youth who received services as usual, those in the STRIVE intervention showed significant reductions in sexual risk behaviour, substance use, and delinquent behaviours (Milburn et al., 2012). Another intervention, ecologically based family therapy (EBFT; Slesnick & Prestopnik, 2005), uses a family systems orientation and was developed for adolescents in shelters (Slesnick, Guo, Brakenhoff, & Bantchevska, 2015; Slesnick & Prestopnik, 2005, 2009). The intervention has been rated as a promising evidence-based practice by the National Institute of Justice (2014) and as a supported evidence-based practice by the California Evidence-Based Clearinghouse for Child Welfare (2016). Studies report that the treatment effects observed for substance use and behavioural problems last longer for youth receiving EBFT compared with those receiving motivational or behavioural individual treatment (Slesnick, Erdem, Bartle-Haring, & Brigham, 2013; Slesnick, Guo, & Feng, 2013). Moreover, family functioning has been found to be significantly improved for families in EBFT compared with those undergoing individual treatment (Guo, Slesnick, & Feng, 2016). Caregivers of adolescents who have left home have shown reductions in depressive symptoms after attending family therapy with their child (Guo, Slesnick, & Feng, 2014). These studies provide evidence for the superior effects of family therapy over non-family interventions.

OVERVIEW OF ECOLOGICALLY BASED FAMILY THERAPY

In general, differences between specific family systems therapy approaches on family and individual outcomes have not been observed, likely because these therapies share an underlying theoretical orientation. Conceptually, EBFT considers the bidirectional influence between mother and child from a family systems perspective. Family systems theory suggests that substance use and related problem behaviours depend on interactive processes within the family system, and that every family member influences and is influenced by other family members (e.g., Bowen, 1974). The concept of mutually interactive processes between parents and children is similarly highlighted in Bell's (1971) control system theory and Patterson's (1982) coercion model. These theoretical models provide a conceptual guide for research, and a significant amount of empirical evidence

supports a closely linked bidirectional relationship between parental psychopathology and child maladjustment (Connell & Goodman, 2002; Kane & Garber, 2004), especially during adolescence (Gross, Shaw, & Moilanen, 2008).

Although this chapter describes EBFT, it is likely that other family systems therapies, regardless of their emphasis, would result in similar positive benefits for adolescents and their families. Typical of family systems therapy, running away (or being pushed out of the home) and related individual and family problems are considered to be nested in multiple interrelated systems. That is, while the family system is considered the most powerful influence on individual members, other systems overlap to create or relieve stress (e.g., school, work, neighbourhood), affecting individual and family adjustment. Although EBFT includes case management to address the systems impacting the family, we focus on the family systems therapy component of EBFT and present commonly observed themes in working with families with an adolescent who has left home.

INTERVENTION COMPONENTS

SESSION LOGISTICS

EBFT involves 12 sessions of family therapy that run for 50 minutes. Frequent meetings early in therapy capitalize on the momentum of motivated family members to meet and work through the crisis of the child leaving home. Treatment is most often provided in the family's home or wherever the youth might be residing (e.g., shelter, foster home). If family members are reluctant to have the therapist come into their home for the sessions, the family should be invited to meet at the clinic.

TRAINING

Thorough training in EBFT involves reading materials, discussion, role play, and co-therapy opportunities with debriefing. New therapists should learn both the theoretical rationale and practical application of EBFT techniques before they conduct their first independent therapy session. Comprehensive training can help increase treatment adherence and competence. Typically, the most difficult aspect for therapists learning family systems therapy is

developing a relational frame, including implementation of relational interventions. That is, the therapist must consider that the individual problems can best be understood and addressed when they are examined from a relational lens. Therapists must be adept at being able to guide family members to this new way of thinking.

ENGAGING ADOLESCENTS & PRIMARY CAREGIVERS

Most adolescents are not seeking psychological services or therapy when they enter a shelter. This means the therapist should not discuss the intervention as therapy. Instead, the therapist taps the youth's motivational goals to facilitate engagement in the intervention. Being called an advocate or ally better describes the therapist's role in the intervention. The advocate supports youth around various issues, for example, school, criminal justice–related problems, and family relationships. To increase engagement, the advocate allows the youth to take the lead and emphasizes the advocate's role as an ally.

Parents or other primary caregivers may be reluctant to meet with the therapist and child given their own substance use problems, negative experiences with the mental health or social services system, and marital or financial stressors. They may feel hopeless, angry, or fearful of being blamed for the current situation or the child's problems. The therapist must take caregivers off the hook by telling them that they will not be blamed for the situation. It can then be explained that the advocate needs their assistance to help the child, and that the child has requested assistance. If the caregiver (or child) refuses to meet together, separate meetings should be scheduled to continue the negotiation process until the family is ready to meet together.

FAMILY THERAPY TECHNIQUES

Instead of considering the adolescent or the caregiver as the problem, the therapist helps the family consider that no one is to blame for the problems. Family therapy uses several techniques to create this shift in thinking among family members. In general, these techniques offer new interpretations of people and events. For example, reframing and relabelling offer a less negative view of a behaviour (e.g., "Maybe John acts that way because he doesn't know any other way to tell you he is worried about you?"). Perspective-taking develops empathy (e.g., "When you say that, how do you think John feels?"). Relational interpretations and

questions draw attention to relational patterns (e.g., "Perhaps you question your ability to hold the family together when John does that?"). The focus of sessions should be on the relationships among family members, ineffective communication, and how harmful strategies or behaviours are used to meet family members' emotional and interpersonal needs. The early sessions focus on developing caregivers' and adolescents' readiness to tap or renew the underlying bond of love and care that can open the way for change. When family members begin to understand problems as residing in family interaction, they are more open to learning and implementing problem-solving and communication skills to resolve conflicts.

COMMON THEMES AMONG FAMILIES

In our work with youth who have left home and with their families, we have observed common situations. In this section, we describe these situations and suggest ways to intervene.

LEAVING THE SHELTER OR HOME

Some adolescents leave the shelter or the home to which they returned after the shelter because of interpersonal stress or family conflict. Other youth leave to spend time with a boyfriend or girlfriend, while others leave with a group of friends. Caregivers can have different reactions. If leaving is not a common event, caregivers might feel terrified, fearing for the child's safety and hoping for an expeditious return home. They might call the caregivers of the child's friends or search for the child in popular hangouts. The therapist should provide support and set up an emergency meeting. This includes addressing caregiver guilt and fear. It also means advising caregivers to call the therapist when the child comes home so a transitional meeting can be arranged. In most cases, caregivers are asked not to discuss the episode until this meeting occurs in order to prevent further conflict, and to maintain the child in the home.

Finally, the therapist should try to obtain permission from the caregiver in the first or second session to allow the adolescent to call the therapist in confidence should the adolescent leave. In most cases, the caregiver will agree to this; in turn, the adolescent will usually agree to let the therapist tell the caregiver that the adolescent is okay. In this way, the therapist can ensure the adolescent is safe and intervene with permission.

TRANSITIONING BACK INTO THE HOME

When the child returns home from the shelter, many families have described a period of peace and harmony. This honeymoon period is often followed by the same troubles and conflicts that occurred before the child left home. The therapist must explore expectations of both caregivers and their child. Caregivers often expect their child to stay in school, abide by an established curfew, and remain free of alcohol and drugs. The child, on the other hand, might expect more freedom and respect from caregivers. If the caregiver or child does not meet the other's expectations, the therapist must facilitate negotiation and compromise by having family members practise perspective-taking, communication, and problem-solving skills.

Problem solving, communication, and coping skills training are also vital when expectations are established and not met. Anger management, including being able to leave the situation and return when emotions are calm, is often a prerequisite to addressing conflict and disappointment. Negative interaction patterns often develop over a long period of time and require redeveloping trust among family members, reconnecting to underlying love and care, practising new skills, changing family members' negative attributions, and having patience. When conflicts occur and the family has not yet reached the necessary non-blaming interpersonal frame, the family should be encouraged to discuss the problem only in therapy. Depending on the nature of the situation, the family can be advised to call the therapist for an emergency session if the issue cannot wait until the next scheduled meeting. For some families, conflict leads to extreme confrontation and to the youth leaving home. Scheduling a therapy session can reduce this possibility and increase the chances that all family members will address conflict and disagreement in a collaborative, problem-solving manner.

CAREGIVERS UNDER INVESTIGATION FOR CHILD ABUSE

If the youth's primary caregiver is under investigation for abuse, the therapist must contact the social worker assigned to the case prior to the first therapy meeting to ensure treatment is appropriate. In some cases, the caregiver is not allowed contact with the child during an investigation. In other cases, treatment is recommended, which requires coordination with the social worker. The social worker might have a plan for the adolescent, and the therapist can help prepare the adolescent and family for it. The plan might include the adolescent returning home or transitioning from the shelter to foster care or to a group home. None of these options necessarily preclude continued work with the youth and caregivers.

Information during a therapy session might reveal that the caregiver has struck or otherwise assaulted the child. Local laws likely require that child protective services be contacted within 24 hours. In less severe cases, if the family consistently participates in treatment, child protective services might follow the family's progress and consult the therapist about the potential for harm of the child.

CAREGIVER REFUSAL TO ALLOW CHILD TO LIVE IN THE HOME

Some caregivers have reached the point where they no longer want their child to live in their home. When authorities become involved, these caregivers might be officially charged with abandonment. If guardianship is removed and no other relatives wish to take it over, the child is placed in state's custody and might be put in foster care. In our experience, without abuse or neglect charges, this is rare. Other options for the child include transitioning into an independent living program (minimum age is usually 16) or being placed in a group home.

Many caregivers with whom we have worked have felt hopeless, frustrated, and angry with their child. They have said they did everything they could for their child and no longer want to be involved in the child's life. Caregivers may be reluctant to have the child back home for various reasons:

- Fear for their own or another family member's safety;
- Fear that the child will negatively influence other children in the home;
- Fear that the caregiver cannot handle the child any longer; and
- Belief that the child would be better off without the caregiver.

Encouraging caregivers to meet alone with the therapist can provide an opportunity for them to vent these emotions and discuss reasons for not wanting their child back home. At some point in the discussion, the therapist should encourage caregivers to meet with the youth and therapist together, without the goal being to transition the youth back home. This serves to respect caregivers' wishes and also opens the possibility of addressing miscommunications, frustrations, and hurt emotions between caregiver and child. Paradoxically, we have had much success in transitioning youth back into the home when a caregiver initially refused to consider the possibility.

IMPLEMENTATION CONSIDERATIONS

We have identified process themes in working with youth who have left home and with their families. The following section describes strategies for addressing common themes that emerge in implementing family therapy with these youth and their families.

YOUTH OR CAREGIVER OFTEN CALLS THERAPIST WITH CRISES

Youth and caregivers can develop a strong connection with their EBFT therapist based on respect and trust. Caregivers often consider the therapist as someone who can help them care for their child and might call the therapist for assistance. Caregivers who feel powerless to influence their child may seek other supports to help them with family management.

Caregivers who call the police during crises with their child should call the therapist instead, except when the crisis involves violence or life-threatening situations. This strategy increases caregivers' confidence and skills in resolving family disputes. A therapist who is called for assistance directs the family to apply the communication and problem-solving skills learned in the sessions to address the current situation. As treatment progresses, the family should be able to resolve conflict without the therapist's assistance.

YOUTH REFUSES TO TALK IN SESSION

It is not uncommon for youth to refuse to talk in therapy sessions. For some, this indicates a reluctance to participate in therapy. For others, it suggests a lack of trust or comfort with the therapist, caregiver, or both. Therapists often feel frustrated when youth remain silent during a session. They wonder whether to allow that silence, do most of the talking themselves, or even end the session early. Many therapists describe struggling in vain to find a topic the youth will open up to. The session becomes nothing more than a series of questions posed by the therapist, met with mere nods or brief answers from the youth.

EBFT therapists have various options for working with quiet youth. The "ungame" is a therapy card game that helps youth open up and provides a format for addressing therapeutic issues. Art boxes are also useful forums for expressing thoughts and feelings nonverbally.

Out-of-office activities include playing basketball or similar sports that can break the ice for many adolescents who are not initially comfortable sitting face to face with a therapist. Taking the youth to fast food restaurants or for ice cream is another strategy to increase comfort and normalize the therapeutic relationship. When the client becomes more comfortable with the therapist, therapy can move indoors, which might be easier for both the adolescent and therapist to discuss relevant issues. Our program does not advocate sitting in the room with quiet teens. Attempting to force communication or sitting in silence with an adolescent client has limited utility. While silence can be a very useful tool for discussing relationship issues, including intimacy and the therapeutic relationship among adult clients, we have not found it particularly useful as a tool for adolescents.

FAMILY CHAOS WHEN MEETING IN THE HOME

Some families have become accustomed to high levels of chaos in the home, such as several family members talking at once, phones and doorbells ringing, children running through the living room, and caregivers doing several things at once. Although a guest in the client's home, the therapist is there to facilitate important work. The therapy process will be well served by the therapist prefacing the first meeting with the importance of the work the family has come together to do. Doing this work requires that all participants devote their attention to the session. This means turning off phones, not answering the door, preparing drinks or food before the session begins, and staying in the room for the entire session. The therapist must strive to maintain the same controls and professional boundaries that would exist in a clinical office.

The therapist must also maintain an atmosphere of calm and safety for highly chaotic families. Although family members will disagree with one another, the therapist must not allow clients to raise their voice in the session or talk over one another. Family members should not be allowed to criticize, blame, or otherwise demean one another in the session. Allowing these behaviours perpetuates a negative interactional style that will not facilitate positive interpersonal change. In addition, it is likely that the family will discontinue sessions because the therapy will be perceived as unsafe and not useful.

Within volatile or chaotic families, one family member might leave the therapy room abruptly and angrily. That person should be encouraged to return to the session and discuss the situation. For some, leaving the room is an appropriate coping response and might be

an improvement over other coping behaviours. That is, some clients might not have the necessary anger management skills to be able to calm themselves down during the session, and leaving is an adaptive way of preventing a "blow out" in the session. Taking a time out is a practical problem-solving strategy in the home, and can be occasionally tolerated in therapy. However, the goal is for clients to calm themselves without leaving the room, and to be able to articulate their frustration to other family members. It is incumbent upon the therapist to determine at what point the client should be encouraged to remain in the room and walk through the steps for discussing the issue at hand in a productive way, rather than being allowed to leave the room.

OTHER CONSIDERATIONS

The safety of family members must always be assessed because having family members together when there is the threat of abuse could be countertherapeutic and unsafe. This concern aside, it is difficult to identify a family situation or presenting problem in which EBFT would not be appropriate. When family members blame other members for their suffering and the suffering of the family, the therapist must work to reframe the cognitive set of the family member until everyone begins to see that the behaviours are interconnected and that each member influences and is influenced by the others. Furthermore, EBFT can be integrated with other evidence-based approaches for treating specific problems, such as emotional dysregulation, self-harm, or suicidal behaviours (e.g., dialectical behaviour therapy), although the efficacy of such integration has not yet been empirically investigated.

CONCLUSION

Family systems therapy reconnects families to underlying bonds of love and care, and guides families toward considering problems in terms of the relational system rather than as a result of individual deficiencies. As such, family therapy addresses many of the risks associated with leaving home. It resolves the current crisis and prevents future ones. Because therapy involves all family members, positive outcomes extend beyond the youth who has left home to include improved interaction and individual functioning among siblings and caregivers. Although family systems therapy is not always offered by community-based programs, the time and cost of additional training and supervision are likely offset by the benefits observed for individuals, families, and society in general.

Acknowledgement

This chapter was supported by NIH grants R01DA016603 and R29DA011590.

REFERENCES

Barber, C. C., Fonagy, P., Fulth, J., Simulinas, M. A., & Yates, M. (2005). Homeless near a thousand homes: Outcomes of homeless youth in a crisis shelter. *American Journal of Orthopsychiatry, 75*, 347–355.

Bell, R. Q. (1971). Stimulus control of parent or caretaker behavior by offspring. *Developmental Psychology, 4*(1, Pt. 1), 63–72.

Bowen, M. (1974). Alcoholism as viewed through family systems theory and family psychotherapy. *Annals of the New York Academy of Science, 233*, 115–122.

California Evidence-Based Clearinghouse for Child Welfare. (2016). Ecologically based family therapy (EBFT). Retrieved from www.cebc4cw.org/program/ecologically-based-family-therapy/detailed

Carr, A. (2013). Thematic review of family therapy journals 2012. *Journal of Family Therapy, 35*, 407–426.

Connell, A. M., & Goodman, S. H. (2002). The association between psychopathology in fathers versus mothers and children's internalizing and externalizing behavior problems: A meta-analysis. *Psychological Bulletin, 128*, 746–773.

Edidin, J. P., Ganim, Z., Hunter, S. J., & Karnik, N. S. (2012). The mental and physical health of homeless youth: A literature review. *Child Psychiatry and Human Development, 43*, 354–375.

Ferguson, K. M. (2009). Exploring family environment characteristics and multiple abuse experiences among homeless youth. *Journal of Interpersonal Violence, 24*, 1875–1891.

Gross, H. E., Shaw, D. S., & Moilanen, K. L. (2008). Reciprocal associations between boys' externalizing problems and mothers' depressive symptoms. *Journal of Abnormal Child Psychology, 36*, 693–709.

Guo, X., Slesnick, N., & Feng, X. (2014). Reductions in depressive symptoms among substance-abusing runaway adolescents and their primary caretakers: A randomized clinical trial. *Journal of Family Psychology, 28*, 98–105.

Guo, X., Slesnick, N., & Feng, X. (2016). Changes in family relationships among substance abusing runaway adolescents: A comparison between family and individual therapies. *Journal of Marital and Family Therapy, 42*, 299–312.

Gwadz, M. V., Nish, D., Leonard, N. R., & Strauss, S. M. (2007). Gender differences in traumatic events and rates of post-traumatic stress disorder among homeless youth. *Journal of Adolescence, 30*, 117–129.

Kane, P., & Garber, J. (2004). The relations among depression in fathers, children's psychopathology, and father-child conflict: A meta-analysis. *Clinical Psychology Review, 24*, 339–360.

Karabanow, J., & Clement, P. (2004). Interventions with street youth: A commentary on the practice-based research literature. *Brief Treatment and Crisis Intervention, 4*, 93–108.

Meis, L.A., Griffin, J. M., Greer, N., Jensen, A. C., MacDonald, R., Carlyle, M., . . . Wilt, T. J. (2013). Couple and family involvement in adult mental health treatment: A systematic review. *Clinical Psychology Review, 33*, 275–286.

Milburn, N. G. (2007, May). *Project STRIVE*. Paper presented at the annual meeting of the Society for Prevention Research, Washington, DC.

Milburn, N. G., Iribarren, F. J., Rice, E., Lightfoot, M., Solorio, R., Rotheram-Borus, M. J., . . . Eastmen, K. (2012). A family intervention to reduce sexual risk behavior, substance use, and delinquency among newly homeless youth. *Journal of Adolescent Health, 50*, 358–364.

National Institute of Justice. (2014). Program profile: Ecologically based family therapy (EBFT) for substance-abusing runaway adolescents. Washington, DC: Author. Retrieved from www.crimesolutions.gov/ProgramDetails.aspx?ID=375

Patterson, G. R. (1982). *A social learning approach: Coercive family process*. Eugene, OR: Castalia.

Peled, E., Spiro, S., & Dekel, R. (2005). My home is not my castle: Follow-up of residents of shelters for homeless youth. *Child and Adolescent Social Work Journal, 22*, 257−279.

Pollio, D. E., Thompson, S. J., Tobias, L., Reid, D., & Spitznagel, E. (2006). Longitudinal outcomes for youth receiving runaway/homeless shelter services. *Journal of Youth and Adolescence, 35*, 852–859.

Slesnick, N., Dashora, P., Letcher, A., Erdem, G., & Serovich, J. (2009). A review of services and interventions for runaway and homeless youth: Moving forward. *Children and Youth Services Review, 31*, 732–742.

Slesnick, N., Erdem, G., Bartle-Haring, S., & Brigham, G. S. (2013). Intervention with substance-abusing runaway adolescents and their families: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 81*, 600–614.

Slesnick, N., Guo, X., Brakenhoff, B., & Bantchevska, D. (2015). A comparison of three interventions for homeless youth evidencing substance use disorders: Results of a randomized clinical trial. *Journal of Substance Abuse Treatment, 54*, 1–13.

Slesnick, N., Guo, X., & Feng, X. (2013). Change in parent-and child-reported internalizing and externalizing behaviors among substance abusing runaways: The effects of family and individual treatments. *Journal of Youth and Adolescence, 42*, 980–993.

Slesnick, N., & Prestopnik, J. L. (2005). Ecologically based family therapy outcome with substance abusing runaway adolescents. *Journal of Adolescence, 28*, 277–298.

Slesnick, N., & Prestopnik, J. L. (2009). Comparison of family therapy outcome with alcohol-abusing, runaway adolescents. *Journal of Marital and Family Therapy, 35*, 255–277.

Thompson, S. J., Pollio, D. E., & Bitner, L. (2000). Outcomes for adolescents using runaway and homeless youth services. *Journal of Human Behavior in the Social Environment, 3*, 79–97.

Thompson, S. J., Safyer, A.W., & Pollio, D. E. (2001). Examining differences and predictors of family reunification among subgroups of runaway youth using shelter services. *Social Work Research, 25*, 163−172.

Tyler, K. A. (2006). A qualitative study of early family histories and transitions of homeless youth. *Journal of Interpersonal Violence, 21*, 1385–1393.

U.S. Department of Health and Human Services. (2004). *The Runaway and Homeless Youth Act (Title III of the Juvenile Justice and Delinquency Prevention Act of 1974), as amended by Runaway, Homeless, and Missing Children Protection Act (PL 108–96) (42 USC 5701)*. Washington, DC: Author.

Zhang, J., & Slesnick, N. (2017). Discrepancies in autonomy and relatedness promoting behaviors: The effects of a family systems intervention. *Journal of Youth and Adolescence, 46*, 668–681.

ABOUT THE AUTHORS

Laura Cully, BSc, is a doctoral student at Ohio State University, studying human development and family science. She works as a therapist with youth who are homeless and studies the effects of trauma in marginalized groups.

Qiong Wu, MS, is a PhD candidate in the Department of Human Sciences at Ohio State University. Her research examines how maternal mental health problems affect children's well-being through a family systems perspective. She is also interested in investigating the effectiveness of family systems interventions.

Natasha Slesnick, PhD, is professor of couple and family therapy at Ohio State University. Her research focuses on developing interventions for youth who are homeless and their families. She has opened drop-in centres for youth experiencing homelessness in Albuquerque, New Mexico, and Columbus, Ohio.