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Reconceptualizing the Domain and Boundaries of Family Life Education

Many scholars have defined family life education (FLE), and some have differentiated it from other family-related fields. For example, Doherty (1995) provided a definition of the boundaries between FLE and family therapy; however, we believe those criteria can be improved. We explore the professions of family life education, family therapy, and family case management using the questions why, what, when, for whom, and how? After examining these questions for each role, we introduce the domains of family practice to differentiate among them. The approach defines FLE and encourages appropriate collaboration among the fields. Suggestions are made for using this model for

career exploration, reviewing job requirements to assess role consistency and clarity, and for determining the need for and appropriateness of referral and collaboration.

What is Family Life Education (FLE) and how is it similar to and different from other family-related fields? We begin to answer these questions by sharing the following comments that were among those posted on the Certified Family Life Educator (CFLE) listserv in 2010. They are included to illustrate the struggle experienced by many professionals in the field:

“I am bothered by the correlation of FLE with therapy. . . . Certainly the two have similarities, but they are not the same.” Esther Schiedel, MS, CFLE

“For years, we have struggled with developing a clear definition for ‘Family Life Education.’” Amelia Rose, CFLE

“While there is a difference and there is a boundary that goes up at some point between CFLEs and doing clinical work, I do see room for both to work together. I think it depends on the service itself that is being delivered.” Tammy Whitten, LMFT, CFLE

“While there are some similar topics dealt with in FLE as in clinical work, they are different, should be different and need to be different. . . . What might it look like if CFLEs were part of a team approach to addressing family needs? How

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would this be done? How would we work to clarify roles and responsibilities [and] respect each profession's contribution to family health? . . . I hope that in 10, 25, and 40 years we see both more recognition of our field *and* a better collaborative approach to family health." Jennifer Best, CFLE

These quotes reflect the frustrations of many of us in a developing field and provide the context for this paper. The field of Family Studies emerged out of a concern in the mid 19th century regarding the abilities of families to address the social problems of their times (Doherty, Boss, LaRossa, Schumm, & Steinmetz, 1993). Family Life Education provided the means by which professionals worked with families to help them learn to solve these problems (Kerckhoff, 1964; Mace, 1971). This work continues. But, what is FLE? For more than 50 years family scholars have composed stipulative definitions of FLE, descriptions that define the concept according to the particular author for his or her current purposes regardless of other definitions (Thomas & Arcus, 1992). Authors have provided definitions that focus on individuals, couples, and families; relationship development and maintenance; sexuality; personal development; and so forth. Many continued with the focus on problems and problem solving; however, over the decades, descriptions of FLE have shifted to include and even emphasize prevention of problems within families. More recently, FLE has begun to focus on assisting families in identifying and developing their strengths to meet their potentials (Arcus, Schvaneveldt, & Moss, 1993).

Currently, the definition of Family Life Education as accessed on the National Council on Family Relations (NCFR) website for the CFLE program presents the profession's function as using information about healthy family development within a preventive, family-systems perspective in order to teach knowledge and build skills so that individuals and families may function at their optimal levels (National Council on Family Relations, n.d.). It includes recognition of the reality that all families face problems they must solve, as well as the idea that all families possess strengths they can employ to face these challenges.

Although the NCFR's definition begins to describe the scope of FLE, it includes such breadth that it leaves unanswered questions about the boundaries of the field. One important component of this discussion is what FLE

does include. A related question remains: What is beyond the boundaries of FLE or what does it *not* include? How should professionals conceptualize their work with families, and to which family professionals should individuals and families turn for assistance in various times of need? Cassidy (2009) concluded that FLE has made some progress in this area by defining itself through the creation of curriculum guidelines and standards for certification. But, as she also noted, "employers and the public are still unclear on what family life education is and how family life educators differ from social workers, therapists, counselors, etc." (p. 13).

As suggested by Cassidy (2009), one of the areas of professional conflict or tension is differentiating between FLE and family therapy (FT). In 1995, Doherty addressed this issue in an article in *Family Relations*. He created a model of family involvement that included five levels: (a) minimal emphasis on families, (b) information and advice, (c) feelings and support, (d) brief-focused intervention, and (e) family therapy. A primary stated goal of this model was to help family life educators avoid "crossing the boundary into family therapy" (p. 353). This model has been cited extensively and has helped numerous students and professionals situate themselves professionally; however, in our opinion as family life educators, it does not provide an accurate description of FLE, nor does it identify the boundaries and differentiation we seek. Because it addressed only the domains of FLE and FT, it is also incomplete. In this paper we will reexamine the assumptions of Doherty's model and broaden its scope in order to develop a new, alternative presentation of FLE and further advance the development of the profession. We expand the model to include family case management (FCM)—an aspect of social work and other human-service professions. Although we recognize that social work also operates in other areas, such as medical and juvenile justice fields, and that FCM may occur in non-social-work fields, we chose to focus on the designation of FCM as a segment of social work that clearly involves work with families and that can represent an area of confusion when differentiating from FLE.

We acknowledge that all of the authors of this paper are family life educators. Therefore, we are viewing this definitional process as FLE insiders and as outsiders in relation to FT and FCM. Using that perspective and building on

our interactions with and feedback from several family therapists and family case managers, we outline our concerns about the Levels of Family Involvement (LFI) model and propose an alternative and innovative structure. Our goal is to position FLE, FT, and FCM as related but unique professions, rather than suggesting one as more advanced than the others, and to provide assistance for family professionals as they define and identify the parameters of their work.

CONCERNS WITH DOHERTY'S LFI MODEL

Our concerns about Doherty's (1995) LFI model center around three areas: (a) it conceptualizes FLE and FT in a hierarchical relationship, (b) it presents a description of FLE that is inconsistent with the established definition, and (c) it distinguishes between FLE and FT using superficial and sometimes inaccurate criteria.

FLE and Family Therapy in a Hierarchical Relationship

The LFI model is comprised of five levels. Doherty (1995) very clearly stated that only the first three levels are appropriate for FLE. (Actually, just Levels 2 and 3 are appropriate, because Level 1 is conceptualized as not focused on families.) According to the LFI model, a few advanced FLE professionals may occasionally move into Level 4: Brief Focused Intervention. All nontherapists, however, are specifically instructed to avoid intervening at Level 5. Doherty explained that family therapists can help FLE professionals learn to use Level 4 effectively, because Level 4 includes overlap between the professions, but beyond Level 4 family life educators must step aside to let family therapists work with families at the highest level.

Although it is not stated directly, it is implied within the LFI model and its vertical, additive structure that family therapists are able to do everything at the lower levels in the model *plus* what is above those levels. Level 5 addresses tasks that require different training and experience when compared to the tasks at the lower levels, but the model implies that the tasks at lower levels are subsumed in the final level. Doherty (1995) stated, "When family members see a therapist, they know they are in mental health treatment and not in an educational program, although education is also likely to occur" (p. 356). This presumes that

therapists are qualified to provide the educational experiences and that they will have learned to intervene educationally. We question that presumption. Although some marriage and family therapists have had this training, many have not. We contend that FLE training is specific and unique and will not automatically be included in therapy training. (Later sections of this paper outline these and other unique characteristics.) Therefore, we assert that this is an inappropriate distinction to make between FLE and FT.

The LFI hierarchy also states that dealing with feelings and support is a higher order professional skill (higher on the model's ladder) than dealing with information and skills. We question that assumption. Additionally, putting those two categories in separate levels suggests that knowledge and skills can be taught without referring to feelings and support and vice versa. As the title of an article by Mace (1981) indicated, it is "a long, long road from information-giving to behavioral change," and there has been much controversy about the steps and their sequence along that road. If behavior change and positive end results are the ultimate goals of educational interventions, these interventions, although they may occur in a different order, are likely to require attitude changes, knowledge gain, skill development, increased perceptions of support, and self-reflection regarding feelings and motivations. Campbell and Palm (2004) highlighted the importance of needs assessment as a step in program planning and development, and eliciting and assessing participants' feelings, values, and attitudes are presented as critical parts of that process. Separating information and advice from feelings and support is neither possible nor desirable. It takes considerable skill to educate families in all of these areas—information, skills, feelings, and support—but we assert that it is most effective when all are addressed. From an educational point of view, the LFI levels leave us looking for a clearer description of professional involvement with families that recognizes both the overlap and the uniqueness of FLE and FT without placing them in a hierarchy.

Inconsistent Definition of FLE

FLE has been defined most clearly in application to the certification program for family life educators (CFLE) by the National Council on Family Relations, in which the NCFR considers FLE to involve "prevention and education

for individuals and families relevant to the 10 FLE content areas” (National Council on Family Relations, n.d., ¶ 2). The 10 FLE content areas include (a) families and individuals in societal contexts, (b) internal dynamics of families, (c) human growth and development across the life span, (d) human sexuality, (e) interpersonal relationships, (f) parenting education and guidance, (g) family resource management, (h) family law and public policy, (i) professional ethics and practice, and (j) family life education methodology (National Council on Family Relations, 1984, 2009).

In contrast to this broad definition, the LFI model places some of the CFLE content areas in the FLE realm and others in the FT domain. Doherty (1995) stated that Level 4 of the model is “confined to parenting related issues [whereas] Level Five may move beyond parenting into couple relationship issues” (p. 356). He further stated, “Level Four deals only with issues of parenting, not marital functioning, psychological disorders, or personality problems of adults” (p. 355) and that “anger management with children is appropriate [at Level Four], but anger management with one’s mother-in-law or boss is not” (p. 355). In the LFI model, couple relationships are excluded from the knowledge base a professional should hold until Levels 4 and 5, and family systems theory is not identified as an important theoretical background context for any levels below 4.

Although we agree that psychological disorders and personality problems are outside the realm of FLE, we contend that *education* about couple and family relationships, in addition to education about parenting, is very appropriate within FLE. Indeed, Arcus (1995) contended that an “early specialization in family life education was that of marriage education” (p. 340). As stated in the definition of FLE on the NCFR’s website, FLE professionals should understand the basics of the entire family system in all of their work. Clearly, all 10 CFLE content areas have been identified by the NCFR as relevant for FLE. So the LFI framework is inconsistent with the NCFR’s conceptualization and does not accurately distinguish between FLE and FT.

Superficial and Inaccurate Criteria

As stated above, a differentiation between FLE and FT based on which of the 10 CFLE content areas is included is not appropriate. There is

significant overlap in the content areas addressed in both fields. In a similar way, we believe it is not adequate to draw the boundaries by focusing on the type of clientele served by FLE and FT professionals. Doherty (1995) wrote, “some parents’ needs and problems are too intense to be worked with constructively in an education/supportive approach” (p. 355). He went on to say that Level 4 is for “families who are in high-risk situations . . . [such as] teen parents with family and peer problems, families involved in the mental health or child protective services systems, and parents facing the stress of a chronically ill or disabled child” (p. 355). This statement suggests that audience type determines appropriate levels of intervention. He asserted that an active problem-solving approach goes beyond Level 3, and, as he stated several times in the article, therapists need to help educators provide services above Level 3.

We fully agree that work with audiences in high-risk or high-need situations requires professionals to be highly skilled and experienced, but we also believe that those audiences may need various types of services, including those within the scope of FLE practice. For example, assessment of family situations, problem solving, goal setting, and helping families develop a plan of action are activities that Doherty (1995) identified as occurring in Level 4 work. These activities are not only appropriate for both the content and the methods of FLE, but include the skills that many FLEs possess. Darling, Fleming, and Cassidy (2009) examined the importance of these activities within a FLE practice-analysis survey conducted with CFLEs and a comparable group of noncertified family practitioners. Among the tasks that were rated high in importance in that study were “assess family dynamics from a systems perspective,” “evaluate family dynamics in response to crisis,” and “assist individuals and families in effective developmental transitions” (Darling et al., 2009, p. 336). These tasks fit within the Level 4 activities in the LFI model described by Doherty (1995), where he indicated they belong in the domain of therapy. We question this assertion and declare that these tasks may be completed appropriately in different ways by therapists and educators.

Consequently, FLEs can be very effective with high-need populations, such as teen parents or incarcerated fathers, by providing research-based information or materials, support-group opportunities with open sharing

and peer support, or skill-building sessions that teach problem solving and goal setting. Those audiences also could be served by a therapist through therapeutic interventions designed to address psychological issues or dysfunctions. We conclude that defining FLE by target audience is another LFI model approach that does not satisfy our quest to identify the boundaries defining FLE and other family professions.

In summary, FT and FLE are different careers with different certification or licensure requirements. It is important for professionals to understand the boundaries, but Doherty's (1995) LFI model does not adequately address these boundaries for our purposes. So how can the two fields and other family-related professions be differentiated?

DIFFERENTIAL PATHS TOWARD HEALTHY AND EFFECTIVE FAMILIES

Professional identity confusion is not limited to FLE versus FT, but also includes family case management and other family professions (Cassidy, 2009). Consequently, our analysis examines three common and overlapping professional roles that all focus on family well-being: family life education, family therapy, and family case management. We focus on the professions and roles themselves rather than on the individuals performing those roles, because many professionals fill multiple roles over time. Therefore, we focus on what those roles involve, the approaches taken by each, and when each may be appropriate. To take a fresh approach in differentiating these three roles, we use the journalistic questions: Why? What? When? For whom? and How?

Why?

FLE, FT, and FCM each defines its purpose: *why* that discipline works with families. All three roles identify a similar long-term goal: healthy, competent, and happy family members and relationships. The specific purpose of each occupation is, however, different, leading to various identifiable outcomes to meet that ultimate goal.

Why Family Life Education? According to the NCFR website in the section entitled "What Is Family Life Education," the purpose of FLE is to teach and foster knowledge and skills related

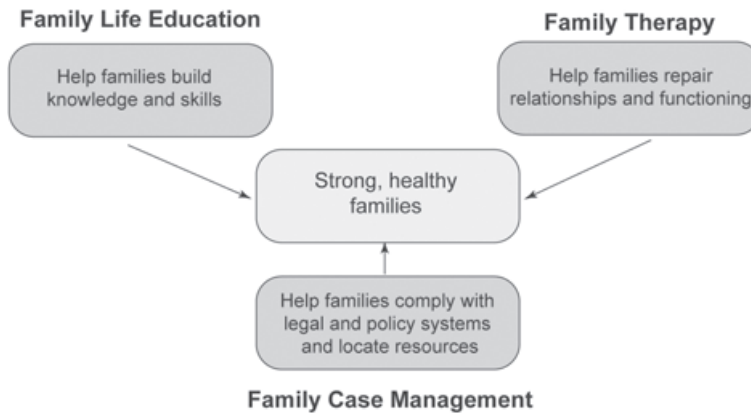
to communication, typical human development, good decision making, positive self-esteem, and healthy interpersonal relationships (National Council on Family Relations, n.d.). By doing this, FLE's goal is to increase healthy family functioning and help family members use their strengths to prepare for and deal effectively with risks and dangers.

Why Family Therapy? A statement of the purpose of Marriage and Family Therapy can be found in a section entitled "What Is Marriage and Family Therapy?" on the American Association of Marriage and Family Therapy website (American Association of Marriage and Family Therapy, n.d.). The statement explains that FT is "an intervention aimed at ameliorating not only relationship problems, but also mental and emotional disorders within the context of family and larger social systems" (§ 3). The long-term goal, as stated on that site, is stable, long-term, emotionally enriching relationships as a way to improve the state of society.

Why Family Case Management? The U.S. Department of Health and Human Services' Administration for Children and Families website includes information about family-centered practice (U.S. Department of Health and Human Services' Administration for Children and Families, n.d.b) with a section called "Overview." It explains that the purpose of family-centered practice is to work with families "across service systems to enhance their capacity to care for and protect their children" (§ 1). The primary focus is on the children's needs, using strengths-based programming to advocate for improved conditions for families. It supports and stabilizes families by reunifying them or building new families and connecting them to resources. In family-centered case management (U.S. Department of Health and Human Services' Administration for Children and Families, n.d.b), the goals are to encourage families to use their skills to access resources, participate fully in services, and evaluate progress in reaching desired goals. In both of these sources, the focus is on crisis intervention and resource management to increase the stability, safety, and well-being of children and families.

Comparison of purposes. All three professions—FLE, FT, and FCM—share a vision of healthy and strong families, but the intermediate

FIGURE 1. WHY?



purposes vary across the roles. Those differences are illustrated in Figure 1. FLE concentrates on increasing knowledge and skills by providing information, tools, and strategies. The goal is to motivate and equip families to improve their lives and their functioning. FT, in contrast, attempts to ameliorate problems, which may be individual or relationship based, but the purpose of therapy is to correct a condition that is keeping families and individuals from functioning optimally. FCM also works with families who are facing problems, but its goal is helping families to negotiate and comply with systems and supports. Professionals using FCM focus on fixing *situations* more than people, but they do assume that there is a problem to be addressed. These intermediate goals have direct linkages to differences in methods and approaches used by the three professions. Those differences will be explored further in several of the following sections.

What?

What is the content or research base that professionals use as their foundation for working with families? Answers to this question across the three roles show significant overlap. FLE, FT, and FCM use similar literature and research to inform their work, because they all focus on families. There are, however, some areas unique to each role as well.

What is Family Life Education content? Although literature related to FLE has been

in existence for over a century, the specific content of FLE was first published in 1984 when a task force of national experts from the NCFR introduced the *University and College Curriculum Guidelines* for FLE curricula and the *Standards and Criteria for Certification of Family Life Educators* (National Council on Family Relations, 1984). These guidelines represented the required knowledge base for the professional practice of FLE and have been commonly referred to as the FLE “10 content areas.” An understanding of each of these areas was deemed essential to effectively practice FLE, and a recent survey of FLEs has confirmed that the areas are still relevant (Darling et al., 2009). (These 10 content areas were presented earlier in the paper.)

What is Family Therapy content? In a process similar to that followed by the NCFR, the American Association for Marriage and Family Therapy, along with interested stakeholders, defined the domains of knowledge and requisite skills that provide the basis of the practice of FT. The ultimate goal of establishing these competencies was to improve the quality of services delivered by marriage and family therapists. The six core competency categories, which contain 128 specific competencies, are (a) admission to treatment; (b) clinical assessment and diagnosis; (c) treatment and case management; (d) therapeutic interventions; (e) legal issues, ethics, and standards; and (f) research and program evaluation. These domains focus on types of conceptual, perceptual,

executive, evaluative, and professional skills or knowledge that are central for family therapy.

What is Family Case Management content?

FCM is only one type of case management within social services. It is not as clearly identified as a separate profession as the other two groups presented in this paper, so we were not able to locate one overarching list of competencies and areas of knowledge for family case managers. There are certification programs overseen by organizations like the American Academy of Case Managers within the American Institute of Health Care Professionals (2006) and Center for Case Management (2002), but those organizations only partially encompass work with families. We found two national documents that provided insight into family case management. For example, a training manual for FCMs that was created by the Office of Child Abuse and Neglect within the Department of Health and Human Services (DePanfilis, 2003) included eight components: (a) theories and philosophies of casework, (b) the helping relationship, (c) legal requirements, (d) intake, (e) assessment and investigation, (f) case planning, (g) service provision, and (h) case closure. Not surprisingly, considering the source of this list, a major focus in these guidelines is on child abuse and neglect, foster parenting and adoption, and removal of children from homes or reunification. Second, in a presentation developed for the National Center on Elder Abuse by the National Adult Protective Services Association (2005), 22 modules are listed to cover core competencies of that profession. These include values and ethics; agency standards and procedures; the aging process; mental illness, substance abuse, physical abuse, and so forth; specific case management steps; collaboration/resources; and legal issues and law enforcement. In both lists of FCM competencies, the content centers on best practices to ensure the safety, permanence, and well-being of families along with a knowledge of community resources necessary to link clients to the supportive services they need. Within these lists there is minimal focus on family roles and relationships.

Comparison of the content. This exploration of the content that forms the foundations for FLE, FT, and FCM highlights several similarities

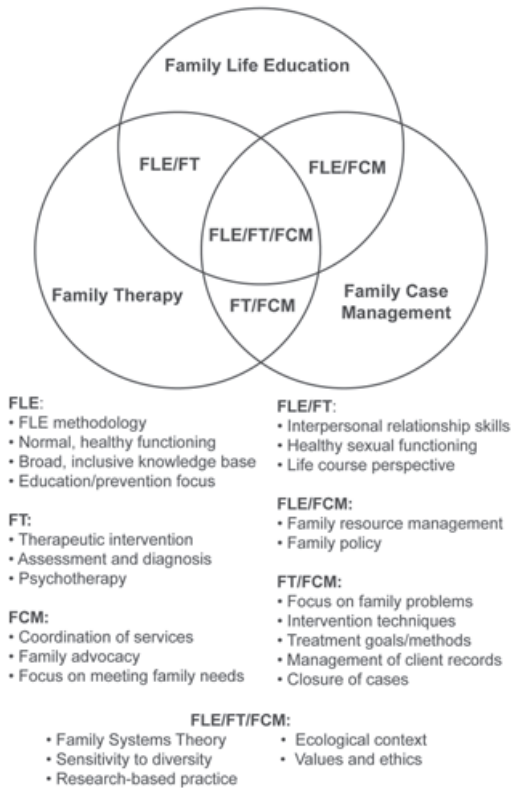
among the three roles, such as understanding systems theory and concepts; using relevant research to inform practice; attention to diversity (gender, age, socioeconomic status, culture, race, ethnicity, sexual orientation) and larger social systems; and incorporating professional ethics and standards of practice including a defined scope of practice and competence. Each professional domain also includes unique areas of content. Of the 10 FLE content areas, one of them, Family Life Education Methodology, appears to be exclusive to FLE and essential for its practice. In the same way, each of the other roles includes its own content base related to methodology. FLE also includes a stronger emphasis than the other areas on healthy family functioning and, with its 10 content areas, is based on a broader and more inclusive knowledge foundation. On the other hand, the focus on service delivery is much greater in the other roles. In comparison to FLE, the competencies of FT and FCM focus in greater depth on specific knowledge, behaviors, and skills related to the practice of FT and FCM, including assessment and diagnosis; understanding the effect of medications; treatment goals and modalities; state, federal, and provincial laws that apply to FT and FCM; maintaining client records; and closing cases. In addition, FT guidelines include references to licensing, billing, and psychotherapy, and FCM competencies include a focus on understanding specific problems families may face that would account for them being referred for case management. Additional content categories that are shared by pairings of the professional domains are indicated in Figure 2.

When?

The next question we address is When? This question considers two issues: When do practitioners in each role deliver services to families and what is the time orientation of those services?

When are services offered? This question addresses when the services are delivered in respect to the occurrence of the families' problems or concerns. A traditional argument has concluded that FLE addresses prevention whereas FT and FCM focus on intervention. This implies that FLE is offered only before problems occur and FT and FCM after crises or problems are encountered. The definitions of

FIGURE 2. WHAT?



prevention and intervention, however, often are not clearly distinct and may even overlap. For example, Webster's *Dictionary* defines *intervene* (n.d.) as "to interfere with the outcome or course, especially of a condition or process (as to prevent harm or improve functioning)," thereby using both "intervention" and "prevention" in the definition. Consistent with this definition, Guerny and Guerny (1981) asserted that intervention can take place anytime—before a problem needs to be faced, while someone is struggling with the problem, or after an individual has struggled with the problem and has been unsuccessful. Most often, many health, social service, and education professionals label these categories as primary, secondary, and tertiary *prevention* rather than intervention. Primary prevention has as its goal to protect healthy people or relationships from experiencing harm before it occurs. Secondary prevention occurs after problems, conflicts, or serious risk factors have already been identified. The goal is to halt or slow

the progress of the problem in its earliest stages, and in the case of harm, secondary-prevention goals include limiting negative long-term effects and preventing further harm. Tertiary prevention focuses on helping people manage complicated, chronic, and/or long-term problems and repair damage. The goals include preventing further harm and restoring or maximizing the quality of life.

Although one scheme uses the term "intervention" and the other "prevention," they are describing similar strategies of working with families. As outlined above in the *Why?* section, FLE, FT, and FCM are all interested in helping families make changes to increase their health and well-being; however, where each domain fits in the prevention and intervention frameworks helps us identify some of the answers to the question *When?* Guerny and Guerny (1981) suggested that FLE deals with the first two levels of intervention, because it includes skill building (which is essential in FLE) to influence behavior. We also would assert that FLE fits within the first two forms of prevention within that framework. Within both frameworks, FLE focuses on providing services for families before problems arise or early in the process. FT, however, fits best within the second and third categories of both schemes, and FCM fits most clearly in the third category. The second and third categories focus on solving problems during or after an issue has surfaced. To depict some of these relationships, as well as the unique focus of each field, we present the continuum in Figure 3 to illustrate the first component of the time aspect of working with families.

What is the time orientation of services? In addition to the concept of when services are offered to families, we would like to propose that the issue of "when" also extends to the *time orientation approach* that is taken with families (see Figure 4). FLE often deals with issues and challenges in the present and the "here and now" while intended outcomes are projected into the future. FLE often is conducted at times of transitions or is linked to developmental processes (both normative and nonnormative) occurring within families. Although some programs may encourage participants to reflect on their past experiences, such reflection is not essential, as programming is designed to equip families for current challenges and those yet to come.

FIGURE 3. WHEN? TIMING OF SERVICES.

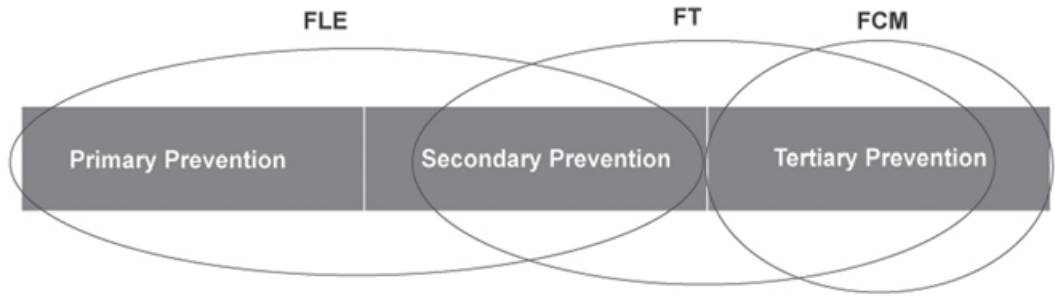
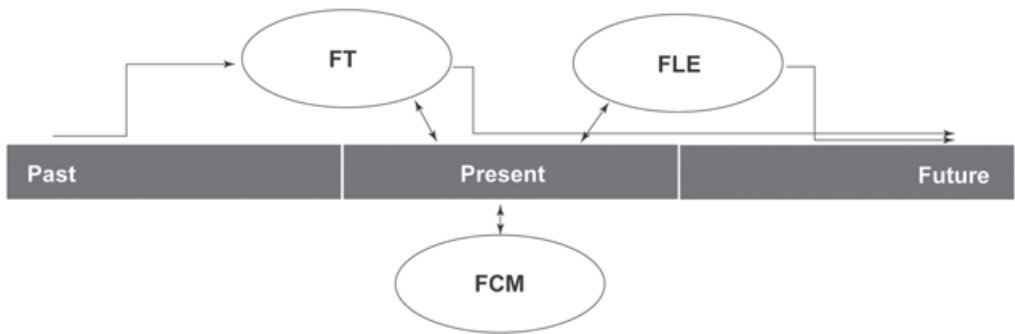


FIGURE 4. WHEN? TIME ORIENTATION OF SERVICES.



Many FT approaches, in contrast, address past family experiences and issues in order to help members understand and make changes in the present and future, adhering to the belief that a family’s history influences its current patterns of interaction. For example, a basic premise of Bowen’s (1976) concept of multigenerational transmission suggests that previous generations influence present behavior and that examination of these past influences can help to prevent further repetition of these negative patterns in the present and future (Hanna, 2007). Therapists address issues of triangulation and use genograms to examine family-of-origin patterns. These techniques may be beneficial in treating traumatic childhood issues, such as abuse, or to inform the origin of beliefs that guide current interactions (Hanna, 2007). (It should be noted, however, that some current FT models are present and future oriented.)

Finally, FCM often is precipitated by a current crisis or need. Families targeted by these services are viewed as in jeopardy or violation of the

FCM goals of well-being, stability, and safety. Services are provided to protect families and family members and facilitate the provision of those basic needs as soon as possible. In this way, the time perspective in FCM is focused on present needs and solutions. Rarely do family case managers have the charge or opportunity to deal with either past or future time periods.

For Whom?

For whom are FLE, FT, and FCM intended? Overall, the two primary factors that determine the recipients of services within these professions are eligibility and motivation. Whereas eligibility is determined by the professional delivering the services and often is based on ascribed needs, motivation represents the perception by the service recipients that the service is needed and appropriate on the basis of felt needs (Powell & Cassidy, 2007).

A number of definitions of FLE state that all individuals or families are potential participants. Professionals are encouraged to target their

programs to specific audiences as much as possible, so that, although virtually everyone is eligible for FLE programming, eligibility for specific, individual programs is ideally much narrower. For example, FLE often is related to normative developments that may be age related or event related (e.g., becoming a parent, preparing for retirement) and may thereby define a particular potential group of participants. FLE also may be related to nonnormative developments or transitions related to some but not all individuals (e.g., loss of job, parenting special-needs child; Arcus & Thomas, 1993). FLEs consider the *educational* needs of a target audience or population, use the needs to determine eligibility for the program, and recruit participants. Theoretically, FLE programs could be designed for any individuals and families, as long as participants are prepared to function in an educational setting. FLE programs are designed for a variety of populations and for individuals across the life span (Arcus & Thomas, 1993). As such, FLE is very inclusive in its answer to the *For whom?* question.

Although participation in some FLE programming may be mandated or based on the needs of particular individuals, most programs are populated with participants who are motivated to participate or have felt needs. If individuals recognize a need for information and skills and see that a program will fill these needs, they are likely to attend. FLE participants generally are individuals or families who are committed to learning skills and information that will help them strengthen their family well-being.

FT tends to focus on families who are experiencing specific types of problems (Hanna, 2007). Definitions of FT identify eligible participants as individuals or families who have been identified or diagnosed as having functional difficulties or who are experiencing crisis or trauma and are willing to participate in a therapeutic environment. The motivation to participate grows out of an awareness of those difficulties, whether the awareness comes beforehand, leading families to engage therapy services, or after formal diagnosis that could even lead to court-mandated therapy.

Families become eligible for FCM when they enter the government child and family welfare system, most often because of reports of child or adult abuse and neglect, or have been found to be in violation of another public regulatory system. There are specific guidelines for eligibility that

are determined by local, state, and/or federal guidelines, laws, and regulations. Motivation of families to participate in the services is helpful, but services are rarely a result of a family's initiative.

Figure 5 summarizes these conclusions. Because FLE services are most often voluntary, participation is based heavily on families' felt needs, although professionals may work with mandated audiences, or they could consult family literature to ascribe some likely or anticipated needs of a target audience. FT uses a balance of felt and ascribed needs, relying on clinical assessments to determine needs and encourage families to identify and find motivation from their own felt needs. FCM is based on ascribed needs almost exclusively, using assessments, investigations, and reports to identify families not meeting particular expectations.

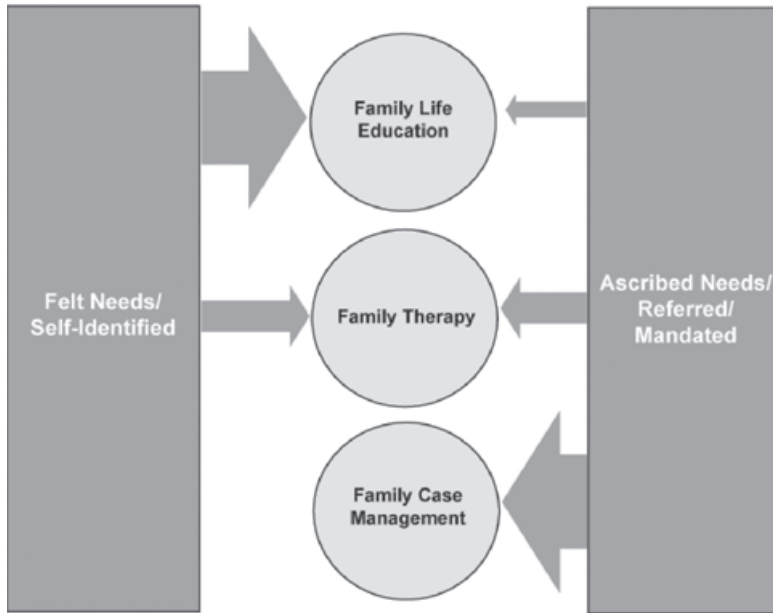
How?

Answering the *How?* question is in many ways the culmination of efforts to define and differentiate the fields of family practice, because it addresses the actual processes that family professionals use when working with families. While the answers to the *Why? What? When?* and *For Whom?* questions are interrelated and in some ways interdependent, it is critical that professionals consult the answers to all of those questions when answering *How*. We include four steps in this category: the processes of determining specific participant needs and setting program goals and objectives, the techniques used when services are delivered, the settings and modes of services, and how families are involved in the services.

How are specific needs determined? The *Why?* question defines the overall purpose of the programming, and the *For whom?* question deals with the felt or ascribed needs that bring a family to the programming. The *How?* question then employs needs-assessment techniques to examine the characteristics of the specific target participants. This is important for all family professionals when they are selecting appropriate content and methods.

In FLE, a basic operational principle is that practices be based on the identified needs of the target population (Arcus et al., 1993). These need-based objectives often emerge from research about families—the answer to the

FIGURE 5. FOR WHOM?



What? question—that creates a vision of healthy, well-functioning families and individuals. Other FLE needs assessments are conducted by looking at community statistics or surveys of the target audience. Although it is recommended that representatives of the target audience be included in the program development process, the assumption is that the program will reach multiple families, so the educator is expected to examine the research literature to identify needs of the target audience as a whole. It is clearly important for educators to adjust and adapt their specific objectives and methods on the basis of the needs and characteristics of particular audiences, but the overall targeted endpoints remain quite similar across comparable audiences.

FT, on the other hand, uses a more individualized approach to determine goals and objectives. In the American Association for Marriage and Family Therapy’s (2004) *Marriage and Family Therapy Core Competencies*, the first two categories are Admission to Treatment and Assessment and Diagnosis. These assessments are performed with individuals or individual families and seek to identify specific strengths, problems, and syndromes that then determine the treatment plans.

FCM begins with steps similar to FT, specifically, intake, assessment and investigation, and case planning (U.S. Department of Health and Human Services’ Administration for Children and Families, n.d.a). Again, the identification of needs and functioning is done with individual families. It measures the ways in which families are and are not meeting the well-being, stability, and safety needs of their members. The result of the needs assessment is case planning to determine the services that will help to build well-being, security, and reunification in the assessed families.

How are services delivered? Beginning with the answers to the *Why?* and *When?* questions and using goals and objectives as a base, appropriate methods for delivering services to families are determined by all groups of family professionals. Methods can be thought of as the process used to meet the needs of the families within the purpose of the profession and to reach the goals and objectives of the program.

FLE tailors its methods to what is known about the population, concentrating on strengths of the targeted families and attempting to empower them, enrich their knowledge and skill levels, and build more positive attitudes and

aspirations. Additionally, when planning FLE programs and the methods that will be used, FLE consults learning styles along with principles of pedagogy and andragogy (Knowles, 1984) to choose FLE methods that will build on and enhance the experience of the learners.

Rather than using lesson plans or curricula, the methods of FT are outlined in a treatment plan that is developed on the basis of the needs of an individual family (Hanna, 2007). FT methods are guided largely by a variety of theoretical frameworks. Family therapists tend to work within one or more of these frameworks, which dictate the particular techniques that are used during therapy sessions (Asay & Lambert, 1999). In a similar way, FCM bases case planning on the identification and coordination of the services that are likely to fill gaps in a family's functioning.

Settings and modes. A third consideration in answering the *How?* question is what setting and mode the work with families will entail. FLE occurs in many different settings (Arcus et al., 1993) as diverse as community centers, schools, or prisons and may occur in different modes. For example, FLE can occur in a mass mode or distance-learning mode (e.g., newsletter or website), an individual mode (e.g., in the home), or in a group mode (e.g., group parent education). All of the decisions about settings and modes are linked, meaning that methods are often chosen on the basis of objectives, which determine the mode of learning and the specific setting.

In contrast, FT is usually delivered as a series of private, face-to-face meetings, with a mean of 12 sessions; approximately half of FT sessions are conducted with individuals whereas the other half are with couples or families (American Association for Marriage and Family Therapy, n.d., FAQs ¶ 5). The settings are less varied than for FLE, most often taking place in private locations with limited distractions to enhance the comfort and protect the confidentiality of the clients.

Settings for FCM are usually in the field and can be in homes, residential institutions, child-care settings, or wherever the professional can find the families. Because the goals of FCM include assessment and monitoring of families, professionals in this role may not have much ability to control the setting. When possible, FCM professionals are encouraged to

use guidelines similar to those of therapists, which include finding a private, comfortable environment (DePanfilis, 2003). The modes of FCM most often involve one family working with one case manager at a time.

How are families involved in the services? A cornerstone of FLE has been the involvement of the learner as an active partner with the program leader and other participants in the FLE process. In a review of FLE literature, Arcus and Thomas (1993) determined that most FLE programs emphasize small-group interaction as well as other interactive strategies such as simulations and role-plays. Duncan and Goddard (2011) discussed the need for instructional balance—a balance between leader talk and participant talk, which highlights the active role of the FLE participant.

Although FT also stresses the importance of involving families in goal setting and in establishing rapport and alliances with the professional, there is generally no interaction with other families included in the service provision, so the sharing of strategies and reactions with other families is not included. FT professionals work first on building trust and openness between themselves and the families. Once a therapeutic alliance has been established, the professionals and families work together to identify objectives that will help both sides reach their desired outcomes.

Finally, FCM strives to include the family in case planning. Models of case management often assemble the immediate family, extended family, and other members of the social support system in order to make decisions about how safety and well-being will be achieved and maintained (DePanfilis, 2003). Guidelines stress the central position of family strengths in this planning. All of the actions are aimed at reducing or eliminating maltreatment and focus on safety, permanence, and well-being of individuals and families.

Reviewing the answers to the *How?* question, one sees clear contrasts among the three roles that are linked to all of the other questions. The FLE process of working with families normally begins with the purpose of increasing knowledge and skills on the basis of the broad literature about healthy family functioning in a primary or secondary prevention context for any families who are motivated and able to function in an educational setting. Programs establish

objectives that are applicable to a population, use settings and modes that are varied and broad, and attempt to involve family input at all levels.

The FT process begins with the purpose of ameliorating family problems using an understanding of family development and therapeutic methods in a secondary or tertiary prevention context for families who have been referred by self or others. The *How?* component starts with an individual assessment of personal and family functioning, is usually delivered to one client or family at a time, and involves family input as partners in the therapeutic process.

The FCM process is grounded in the purpose of helping families comply with regulatory expectations and use community resources on the basis of the foundation of intervention research and in a tertiary prevention context for families in need of services. The *How?* answers begin with an individual family assessment or investigation to assess compliance with or violation of laws and guidelines; then services are offered to families wherever they are, and attempts are made to include families and their support systems to increase adherence to treatment plans and goals.

FAMILY LIFE EDUCATION IDENTITY

We have explored how FLE is distinct from yet related to similar professions by outlining a number of overlaps and contrasts among the fields of FLE, FT, and FCM. In so doing, we attempted to compensate for our concerns with Doherty's (1995) Levels of Family Involvement model by eliminating the hierarchical approach, increasing the consistency with published descriptions of FLE, and using accurate and deeper criteria. We also made the analysis more complete by including family case management in the comparisons. The results of our analysis are summarized in Table 1: the Domains of Family Practice (DFP) Model.

We encourage all family professionals to use the questions in the table to examine their work in many settings. Even though professionals sometimes may begin with an answer to a question that appears at the bottom of the table, all of the questions should be addressed. For example, some professionals are assigned a curriculum to use—answering the *How?* question. Those professionals should address the *Why?* *What?* *When?* and *For whom?* questions as well to make sure there is consistency of purpose and

approach. The same is true for those who begin with an assigned audience or with a particular library of background literature.

DFP can be used in several ways. One way is to review a job setting and ask each of the questions to identify the column in which that job resides. Ideally, a job will fit in one column consistently across the questions that are asked. This will help to place it clearly in one of the professional categories. In some situations, however, the job may fall in different columns. We encourage professionals and supervisors in those settings to review performance expectations and either attempt to build more internal consistency or identify the occasions in which the job will focus on one role versus the others.

A second way to use the model would be for an individual to look carefully at the questions to identify which column or category feels comfortable or best fits his or her skills. This process can not only help individuals with career planning and employment seeking, but also help those counseling others in identifying their career goals. In other cases, FLEs could work to alter the demands of a job already held to more closely fit their training and skills.

Because there is often a high level of confusion and an unclear sense of identity in the family fields, we have another vision of how the model can be used. We encourage professionals who see themselves in the FLE field to use the descriptions in the table as a guide to keep them firmly grounded in the expectations and foundations of FLE. When they feel they are being asked to use methods or deliver services in a way that does not fit their job descriptions or their training, they can seek professionals who do have those complementary skills and work cooperatively to meet the needs of families more fully. Likewise, they can offer to help professionals in other fields by contributing FLE skills and knowledge.

Whereas some people may function in just one of these roles, others have the training, expertise, and need to perform multiple roles and use varying strategies to meet the needs of the families with whom they work. When moving across roles or combining them, however, it is important to confirm that they have the preparation and background to make this transition. Part of the ethical guidelines for all three fields should include an expectation that each professional will refrain from operating outside his or her scope of

Table 1. *Domains of Family Practice*

Question	Family Life Education's Responses	Family Therapy's Responses	Family Case Management's Responses
Why? Purpose and goals of work with families	To increase knowledge and develop skills so families may build on their strengths to function at their optimal levels	To ameliorate relationship problems and mental or emotional disorders to achieve stable, long-term, emotionally enriching family relationships	To help families negotiate systems, understand and comply with legal and regulatory requirements to increase family safety, permanence and well-being
What? Content base and foundation	Family and life-span theory and research in the 10 FLE content areas; learning, pedagogical or andragogical and educational philosophies and methodologies	Family and relationship theory and research; therapy-focused philosophies and methodologies	Case management theories and methodologies; research and information about social systems, resources, and policies; information about family dysfunction
When? The timing of work with families	Deal with current family needs and challenges to prepare for and improve current and future family functioning	Cope with past and current family problems focusing on past causes and patterns to improve current and future family functioning	Deal with current problems and immediate crises
For whom? Target population for services	Any individual or family willing and able to function in an educational environment and committed to learning	Individuals, couples, and families who have been diagnosed with functional difficulties who are willing to participate in a therapeutic environment	Families identified as being at risk or who demonstrate a need for assistance in meeting legal and societal regulations
How? Techniques and methods used	Assess family-related educational needs; set goals on the basis of family needs and strengths; can occur in a variety of settings; teach about knowledge, attitudes, and skills; families—individually or in groups—are active in the learning process	Diagnose family problems; identify a treatment plan guided by particular theories or philosophies; occurs in private settings; establish a therapeutic alliance with one family at a time; families have input but little or no interaction with other families	Assess family functioning; set goals to fill gaps in family functioning; occurs in the field; coordinate community services while monitoring compliance, difficulties, and successes; families (may include extended family) participate in services but rarely interact with other families

training and preparation, but also should include the expectation that professionals connect with others who do have that training when necessary to meet the needs of families. For example, if FTs shift into FLE, they should obtain the appropriate training and skills in the 10 content areas of the field, develop educational rather than therapeutic goals, and use FLE methods. Or an FT could establish an alliance with a professional FLE.

Although this analysis could have been applied to other fields such as family policy or family nursing, this article has demonstrated

that FLE, FT, and FCM are related and important but distinct professions. All three recognize the importance of the family context but have different viewpoints, use different tools, and take different paths as they work with families. The three fields are intimately interrelated and interdependent. None is superior to the others; all are critical pieces of the puzzle in work with families. The analysis here should help professionals and those who use their services to identify more clearly each of the domains and the boundaries around them.

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