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WORKING WITH FAMILIES THAT IDENTIFY THE ADOLESCENT AS A PROBLEM: INTEGRATING THE STRUCTURAL MODEL WITH THE SOLUTION FOCUSED APPROACH

BY

MARIA OWENS

A PRACTICUM REPORT

Presented to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree

MASTER OF SOCIAL WORK

University of Manitoba
Winnipeg, Manitoba

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BY

MARIA OWENS

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

of

MASTER OF SOCIAL WORK

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INTRODUCTION

When thinking of adolescence, we remember exciting but awkward years full of challenges, transitions, hope, promise and frustrations. We recall happy times: getting our driver's licence, going 'steady', or prom night. Less positive memories also surface: getting in trouble with the law, being caught drinking or smoking. Adolescence is a time like no other in the life cycle of the individual and the family. Childhood is left behind as the adolescent encounters growing internal and external pressures (Worden, 1991). Internally, the adolescent experiences the onset of puberty and strong changes. Externally, new expectations and demands from others often put the adolescent in "conflictive situations": to whom to be loyal (Worden, 1991)? Also, the question of identity becomes central to the adolescent - who am I? and what do I stand for as a contributing member of society? Because so much is happening so fast, adolescents, parents, and other family members are not certain how to handle the confusion and disruption that is associated with this phase in the family life cycle.

Most families possess the capacity to adapt and move beyond the stress to the next developmental phase. However, there are others who have failed to adjust to this new stage of development. Parents feel that nothing they have tried has worked. Often, there are feelings of discouragement and

despair. These are the families that may present with their adolescents for therapeutic intervention. In order for a therapist to intervene effectively with a family where the adolescent has been the identified problem, s/he must have an understanding of the specific, transitional events during this stage of the family life cycle and how these transitions might produce stress in the adolescent or in other family members. In addition, the therapist must examine the elements that have contributed to the development and maintenance of the problem.

Therefore, this practicum report reviews the literature on the adolescent phase of the life cycle and the family life cycle framework with an emphasis on the adolescent stage of the life cycle. It also reviews the basic assumptions and principles of the structural and solution focused family therapy approaches. Since both models have proven to be effective in clinical situations concerning families with adolescents, I discuss how the two models can be combined. The structural approach was used to assess the family structure and how it functions, and the solution focused approach was used to explore exceptions, encourage co-operation, and build on the clients' strengths. It is assumed that the use of both models provides for a more effective delivery of service.

In the following chapter, I describe the organization of the practicum: the setting and duration; supervision; and clinical evaluation procedures. Three of my clinical cases

are described in detail. The other cases are mentioned in the appendix of this practicum report. The report concludes with an evaluation of the overall practicum experience.

Objectives of the Practicum

In this practicum, I have four educational goals;

1. To develop and acquire assessment and intervention skills in the area of family therapy;
2. To develop a theoretical understanding and knowledge of the models of structural and solution focused therapy;
3. To increase and practice my clinical skills in working with families in a supervised setting;
4. To develop greater experience and skills in relating to families with difficult adolescents.
5. To receive supervision and feedback to help facilitate my professional growth and development.

CHAPTER ONE

THE ADOLESCENT PHASE OF THE INDIVIDUAL LIFE CYCLE

Adolescence has been regarded as a stormy, emotional, and turbulent time by many. Some have blamed physiological factors; others have pointed to peer pressure and intimacy. Theorists such as Erickson (1968) view adolescence as a period of "normative crisis". He defines crisis as: "a necessary turning point, a crucial moment when development must move one way or another, marshalling resources for growth, recovery and further differentiation" (p. 15).

Blos (1979) characterizes adolescence as a period of internal turmoil and emotional complications brought on by physical, biological and psychological changes. He identifies six stages in the adolescent period. In each stage, Blos (1979) emphasizes the process of psychological adjustment to sexual and biological maturation. His view is that "puberty is an act of nature and adolescence is an act of man" (Blos, 1979, p. 405). As the adolescent moves from stage to stage, there is an increased disengagement from parents and increased identification with peers and others.

It is also during these phases that the adolescent's sense of identity and self-knowledge begins to develop and stabilize. The aim of the next section is to provide a brief overview of the developmental and social tasks occurring during the stage of adolescence. The developmental tasks

which commonly characterize the adolescent phase include identity formation, sexuality and achievement of a sense of individuation and autonomy from parents. Related to these are the issues surrounding attachment, separation, and loss during the adolescence phase.

Identity Formation

"Identity is the stable, consistent and reliable sense of who one is and what one stands for as a contributing member of society" (Fullinwider-Bush & Jacobvitz, 1993, p. 87). According to Erickson (1968), "a sense of identity is the most crucial achievement of adolescence in that the formation of identity prepares the adolescent for adulthood by organizing all past and present identifications, attributes, desires and orientations into a coherent and unified representation of self" (Fullinwider-Bush & Jacobvitz, 1993, p. 87). Our understanding of this process has been based upon the work of Erickson (1968), who identified adolescence as a period of identity crisis. Fullinwider-Bush and Jacobvitz (1993) believe that "identity resolution involves two key processes: exploration and commitment" (p. 88).

Identity exploration entails an active search for information about occupational goals, political and religious beliefs, friendships and dating, as well as testing the ways various roles, attitudes and beliefs relates to one's self-

concept (Fullinwider-Bush & Jacobvitz, 1993, p. 88).

On the other hand, the process of commitment entails choices and a strong attachment to a particular set of beliefs and values. People often explore and reflect upon their beliefs and values before committing to them. "In fact, exploring one's own attitudes and values in a specific area before committing to these beliefs is critical to forming a stable sense of self" (Fullinwider-Bush & Jacobvitz, 1993, p. 88). Marcia (1983) also confirms that for the development of a mature and "differentiated ego-identity", it is necessary for the adolescent to question and challenge the existing "familial" value systems, goals and beliefs with which they have been raised.

The adolescents' ability to critically look at the world also allows them to see their parents' strengths and faults. As part of this process, they begin to "integrate into their own personalities parental attributes that will help them on the road to adulthood, and attempt to discard those they view as negative" (Preto & Travis, 1985, p. 26).

When adolescents fear losing their sense of self, they blindly accept others' value systems and beliefs. On the other hand, adolescents may look for models which they can follow and incorporate as their own.

The changes which occur in adolescent identity formation can be a source of stress and conflict in families. According to Steinberg (1987), "the adolescents' advanced reasoning

abilities may make it difficult for the parents to exercise previously unquestioned authority, and the young person may feel entitled to have a say in family decision making" (p. 83). Adolescent "back-talk" may have very little to do with questioning parental authority and may have more to do with their desire to exercise new-found "intellectual" abilities (Steinberg, 1987).

Research has shown that in addition to a supportive and secure family environment, families who provide for individuality and autonomy, and who exert minimal parental control within the family interaction pattern, also appear to enhance adolescent identity formation (Adam & Jones, 1983; Grotevant & Cooper, 1985; Marcia, 1983). "Therefore, for individuation to take place, the family must be strong and flexible. It must constantly strive for a balance of power that allows for experimentation and yet provides protection" (Preto & Travis, 1985, p. 26).

There is variation, however, in the degree to which the strategy is applied to adolescent males and females in families. The developmental tasks assigned to adolescent females are different from those given to adolescent males in the North American culture. As Mackie (1987) states, "For both sexes, the peak of gender role differentiation occurs in adolescence and early adulthood" (p. 147). Most studies on gender differences indicate that the moves of adolescent males toward autonomy and separation are much more likely to be

encouraged, and at earlier ages, than those of adolescent females (Mackie, 1987). More passivity is expected of females, who, as a rule, stay closer to home and accept more parental restrictions than males during these years.

Traditional developmental theory is based upon a "masculine developmental model" and is biased to the point of ignoring the developmental process of females (Streitmatter, 1993). According to Gilligan's (1979) work:

> The traditional developmental theory emphasizes the patterns of successful individuation, a sense of separateness, a growing sense of autonomy and a demonstration of competence through a mastery of the technology of their culture in order to recognize themselves and be recognized as capable of becoming adults (cited in Streitmatter, 1993, p. 57).

Gilligan (1979) explains the bias built in the traditional model:

> For men, identity precedes intimacy and generativity in the optimal cycle of human separation and attachment; for women, these tasks seem instead to be fused. Intimacy precedes, or rather goes along with, identity as the female comes to know herself as she is known, through her relationships with others (cited in Streitmatter, 1993, p. 57).

In essence, females are socialized and oriented towards emotional bonds, attachment, and "connectedness" in their families (Fullinwider-Bush & Jacobvitz, 1993, p. 91).

Gilligan (1979) does not believe that identity formation

is a significant developmental task for females. Instead, Gilligan (1979) maintains that intimacy becomes a central focus for females. There is also a lot of emphasis on connections and on building and maintaining relationships while male identity typically emphasizes separation and individuation. "This focus may lessen consideration by females of those issues which are held important by males and the traditional model of successful identity achievement - autonomy and individuation" (cited in Streitmatter, 1993, p. 57). In fact, the female issues of connectedness and relationship maintenance are quite different from "male" identity issues. Women's sense of self has been very much organized around being able to make and maintain relationships. The threat of disruption of a relationship is often seen not just as "object loss", but as something closer to a loss of one's identity, and thus needing a "transformation of self and of the system" (McGoldrick, 1989). In relation to this systemic perspective is the feeling that human identity is "inextricably bound up in one's relationships with others and that complete autonomy is a fiction" (McGoldrick, 1989, p. 205). Human beings cannot live in isolation. The essence of human experience is affiliation with others.

Preto (1988) notes that most developmental theories adopt a male perspective since they emphasize separation and individuation. She suggests that this creates problems for

understanding identity formation in females who typically rely on relationships and connections and for males who do not pursue separation and individuation.

Sexuality

Puberty not only transforms the physical self, but signals the beginning of the psychological transition to adulthood (Hopkins, 1983, cited in Preto, 1988). The physical and the sexual changes that occur have a major impact on how adolescents see themselves, and how they are perceived by others. "Coping with this upsurge in sexual thoughts, feelings and behaviours is a major task for all family members" (Preto, 1988, p. 258).

Family members may experience confusion and fear when adolescents begin to exhibit their sexual interests (Preto, 1988, p. 258). Parents who are comfortable with their own sexuality may be able to set realistic and sensitive limits on the expression of sexual feelings. The adolescent is able to receive information that s/he needs within a family context that promotes the development of acceptable forms for sexual expression (Preto, 1988).

When parents try to deny, reject or ignore the adolescents' growing sexuality, the development of a positive sexual concept is diminished (Preto, 1988). "The probability of increased feelings of alienation between adolescents and

their parents is greater and risks of premature, excessive, or self-endangering sexual activity are increased" (Preto, 1988, p. 259).

Individuation/Autonomy

During this phase of development, adolescents begin to venture out into the world on their own. The influence of peers becomes important, both for support, advice and a sense of who they are (Preto, 1988). Adolescents begin to rely heavily on their peer group for support and re-inforcement in their quest for separation and independence. There is a strong need for acceptance and a sense of belonging with peers. Therefore, the individuation process is seen as an "internal-psychological" and "external-physical" distancing of the individual from the parental family (Sabatelli & Mazor, 1985).

The adolescent becomes more emotionally autonomous from his or her parents. The adolescent comes to view his or her parents as people with needs, personal characteristics, and repertoires of behaviour not always evident within the confines of the parent-child relationship (Silverberg & Steinberg, 1987). The adolescent also begins to rely less and less on his/her parents while taking more responsibility for his or her own behaviours and decisions.

Adolescents need acceptance and nurturing to develop

strong and separate identities. At the same time, they need security, encouragement and permission to be more responsible for themselves. Autonomy does not mean separating emotionally from parents, but it does mean that the adolescent is no longer as psychologically dependent on parents and has more control over decisions about his or her life (Preto, 1988). Parents who encourage the adolescent's participation in decision making, while maintaining ultimate power in deciding what is appropriate, will promote increased movement towards autonomy in the adolescent.

On the other hand, parents who do not involve the adolescent in the decision-making process may become more dependent and less self-assured (Newman & Newman, 1979, cited in Preto, 1988). Males and females accomplish the task of moving towards autonomy differently. Males appear to be dependent on their parents for a longer period than females (Preto, 1988). However, males seemed to achieve emotional autonomy faster than females. Other findings imply that independence is a more important concern for males than for females, and that parental expectations seem to reinforce that pattern (Preto, 1988).

In spite of changing gender role expectations noted by many authors, many parents continue to socialize their children in traditional ways (Santrock, 1990). "Traditionally, families have given males greater encouragement than they have females for educational and

occupational advancement, independent living and financial self-sufficiency" (Preto, 1988, p. 263). Recently, females have been requesting the same chances and opportunities as males. These demands and expectations by females challenge the values held by previous generations.
"When there are no prototypes to provide role models, the conflict and confusion that are normally experienced during this phase may increase dramatically for families with female adolescents" (Preto, 1988, p. 263).

Families where the parents are able to provide structure, limits, and guidance, while giving adolescents the opportunity to be more self-reliant and independent, often produce competent and caring adolescents. According to Garbarino (1986), "to increase the probability that adolescents will make a successful transition to adulthood, adolescents need stable, supportive, and protective relationships with their parents" (p. 17). Consequently, there is no other social system that has more influence on the adolescent's development than the family (Garbarino, 1986).

Attachment, Separation and Loss

As adolescents begin to spend more time with peers outside their home, their decreasing involvement at home is often experienced by their parents as a loss. According to Preto and Travis (1985):

> The transition from childhood to adolescence marks a loss for the family - the loss of the child. As adolescents move toward greater independence, parents often feel a void. They are no longer needed in the same way. The nature of their care-taking needs to change...adolescents experience feelings of loss as they no longer enjoy the security and self-assuredness of (childhood) latency (Preto & Travis, 1985, p. 28).

A strong and cohesive parental system is essential in supporting and assisting the adolescent in the process of separation. When the parental system is characterized as either overly-controlling, weak or permissive, the task of separation becomes more difficult for the adolescent. In families where parents attempt to control the adolescent, there is a risk that s/he may develop serious "symptomatic behaviour". When parents become overprotective of their adolescents, they discourage them from leaving home. According to Stierlin and Ravenscroft (1972):

> The centripetal pattern of separation has the effect of binding the young person to the family. The young person, in turn, becomes overly dependent on the parents who, while continuing to infantalize their young adult child, also feel resentful about the limitations that the continuing relationship places on their own autonomy (cited in Walsh, 1982, p. 211).

Feelings of ambivalence and guilt typify both generations in this separation pattern (cited in Walsh, 1982). Parents who feel overwhelmed by the task of adolescence may give up all responsibility and seek premature separation or expulsion of the young person from the family.

Normality and Abnormality in Adolescence

The literature highlights the adolescent phase as a period characterized by large amounts of stress, conflict and turmoil. While there is some evidence that the adolescent phase may be a difficult time for families, other studies suggest that most adolescents enjoy positive family interactions and relations (Noshpitz, 1991).

According to psychoanalytic theory, the storm and stress of adolescence which comes in the form of conflict with parents is natural, inevitable and even necessary. The adolescent is expected to be resistive, belligerent and hostile. This view suggests that acting-out behaviours by an adolescent should not be seen as indicators of family conflict or dysfunction. Also, this theory emphasizes that problematic behaviour can be cast off as just a phase, when in fact, it could represent a "real" family problem. Having stated all this, many studies have examined the nature of family relationships during the adolescent phase and concluded that most adolescents do not go through major turmoil and conflict with their parents. Research by Daniel Offer and colleagues (Offer, 1969, Offer & Offer, 1973, 1974, 1975; Offer et al. 1981, cited in Noshpitz, 1991) supported the finding that for the greater number of adolescents there were no observable rebellious behaviour or mood swings, and for those adolescents that have shown some emotional disturbance, it was within

normal parameters. In another study, Rutter et. al. (1976, cited in Garbarino, 1986) surveyed a sample of teenagers in Great Britain concerning the "seriousness" of adolescent problems. They found low incidence of parent-adolescent conflict and their findings also supported the conclusion of the studies done by Offer (1969) where only a small percentage of adolescents experienced conflict and turmoil.

In summary, it would seem that associated with the development stage of adolescence, it may be normal to assume some level of conflict and stress at this developmental stage. As Riegel (1976, cited in Steinberg, 1987) noted, "systems theorists have tended to devalue periods of disequilibrium and view the restoration of equilibrium as the optimal goal. It is perhaps more sensible to view periods of disequilibrium as not only good, but essential for the healthy development of individuals and families" (p. 84).

Most adolescents are able to move beyond the "normative crisis" period to the next developmental phase. However, some adolescents may develop disturbed behaviours and symptoms and may need therapy to move on in the life cycle.

An adolescent exists in a context that includes his or her family, culture, society and community. Therefore, the resolution of the developmental tasks happen within the family system. As a result, one must also understand the context in which the resolution of these developmental tasks occur. In the next section, I will examine the family life cycle in the

adolescent phase in order to look at the family as a whole.

The Family Life Cycle

Haley (1973) and Solomon (1973) were among the first to connect the family life cycle to the field of family therapy. Before the development of the model, symptoms were perceived as an indication of family pathology. The function of therapy was to correct and 'cure' the pathology. The family life cycle offers an alternative view. This perspective views "symptoms and dysfunctions in relation to 'normal' functioning over time and views therapy as helping to reestablish the family's developmental momentum" (Carter and McGoldrick, 1988, p. 4). Furthermore, the model views families moving forward through time, passing through predictable life stages and developing new methods of taking care of themselves and coping with the demands of the external world (Koman and Stechler, 1985).

Recent work done by Carter and McGoldrick (1980, 1988) has not only thoroughly outlined the specifics of a family life cycle paradigm, but has also begun to identify its clinical significance for understanding normal family process. They view the 'family' as an emotional system consisting of at least three and often four generations. Carter and McGoldrick (1988) further state that the generations have an enduring, reciprocal, life-shaping impact upon each other. While one

generation is moving towards old age, the second is struggling with the empty nest, the third with being an adolescent forming important peer relationships, and the fourth with being "inducted into the system" (Carter & McGoldrick, 1988, p. 7). "Naturally there is an intermingling of the generations, and events at one level have a powerful effect on relationships at other levels" (Carter & McGoldrick, 1988, p. 7). Family stresses, which often happen around life cycle transition points, commonly create disruptions of the life cycle and create symptoms and dysfunctions (Carter & McGoldrick, 1988). According to Carter and McGoldrick (1988), "there is growing evidence that life cycle events have a continuing impact on family development over a long period of time" (p. 8). Stress and anxiety in a family may come from relationship patterns transmitted down the generations primarily through the "mechanism of emotional triangling" (Carter & McGoldrick, 1988). These include attitudes, taboos, expectations, labels, and loaded issues with which people grow up. Stress may also be produced by families moving through time, and coping with changes and transitions of the family life cycle. This includes both the predictable developmental stresses and those unpredictable events of daily family life that may upset the life cycle process. Since the individual life cycle takes place within the family life cycle, a convergence of transgenerational and developmental stressors may contribute to individual or family emotional difficulties

(Carter & McGoldrick, 1988). Furthermore, change across the individual and family life cycles can be better understood by looking at the interactions between individual time, family time and historical time.

Based on their three-generational view of the family, Carter and McGoldrick (1988) identified six family life stages; the unattached young adult, the new couple, families with young children, families with adolescents, launching children, and the family in later life. Each stage has a key emotional process that must be successfully resolved prior to the transition to the next stage of the cycle. Carter and McGoldrick (1988) state that the "central underlying process to be negotiated is the expansion, contraction, and realignment of the relationship system to support the entry, exit and development of family members in a functional way" (p. 13). They also suggest changes required at each transition in order to proceed developmentally. An important part of this model is how Carter and McGoldrick (1988) conceive of family development as a dynamic process incorporating two types of changes: first-order emotional changes and second-order changes, or change in the system itself. First-order change is identified by an internal re-alignment of the family system without changing the system itself. Problems within each developmental phase can often be resolved by "incremental" first-order changes. For a family to make a successful transition from one stage of the life

cycle to another, it must not only recognize the key emotional processes connected with each stage, but that they make the required second-order shifts which alter how a family operates in terms of rules, structure and interactions.

The notion that family systems are capable of first and second order changes has been used to account for the difference between functional and dysfunctional families. According to Speer (1970), family systems are like other social systems in their abilities to both maintain or alter their structures autonomously of external pressures. The catalyst for change or stability can occur at a variety of systemic levels. Speer (1970) associated first order change with stability and system maintenance, and second order change with growth and development. Symptom formation arises out of a family's inability to change or maintain its organization and structure to fit the new developmental requirements. This understanding of symptom formation and symptom resolution constitutes the predominant view among schools of family therapy (Falicov, 1988).

According to Haley (1973), "the symptoms appear when there is a disruption in the unfolding life cycle of the family" (p. 42). He further stated that the symptom is "a signal that a family has difficulty getting past a stage of the life cycle" (p. 42). Therefore, "the nature of a failed transition lies more in the failure to complete a process rather than failure to initiate it" (Breunlin, 1983, p. 3).

While the family life cycle model has helped to de-pathologize family problems and identified the process associated with the various transitions, the links between family life cycle changes, individual developmental changes, and therapeutic change, are yet to be clearly specified (Liddle and Saba, 1983).

Along these lines, Terkelsen's (1980) paper, "Toward a theory of the family life cycle", seems to be a step in the needed direction (Liddle & Saba, 1983). He discusses the developmental interaction effects within the family life cycle. Terkelsen (1980) further states that when one member in a family attains a new level of individual maturation, alterations in family structure occur. He emphasizes that even a very small, incremental developmental change can produce widespread modifications in family structure (Terkelsen, 1980). These alterations in the family structure also elicit new behaviours in other family members. As a result, conflict occurs between elements of structure that were previously functional, and now become "dysynchronous". In a similar manner, every developmental need by an individual family member causes disruption in the existing family structures, and results in a modified or new structure through which the novel element is integrated. Terkelsen (1980) identifies three stages that are necessary in order to integrate new elements into the existing family structure.

These are:

1. An insertion stage, in which a new developmental need manifests itself. The new need is recognized and validated by other family members, and behavioral trials are activated.
2. A destabilization stage, in which the new behavioral sequences are added to the existing structure, causing a clash with preexisting elements or patterns.
3. A resolution stage, in which the novel elements are integrated into a merged structure consisting of new and preexisting elements.

The process is continuous, overlapping and incremental. Every developmental step by a family member forces the whole family to make adjustments in functioning. Individual developmental demands influence the whole family, not just one member. Terkelsen (1980) attempts to link individual life cycle changes, family life cycle changes, and therapeutic change, by means of first and second order change. He argues that there are two types of changes: first order change, which is gradual, continuous and does not alter the family structure and; second order change, which is abrupt and discontinuous and involves a change in the elements of the family system. Successful first order developments may pave the way for later, second order development (Terkelsen, 1980). "Each increment of competence takes a member toward the

transition from child to adult status" (Terkelsen, 1980, p. 40). On the other hand, failed first order developments may set the stage for failures in second order development and trigger symptoms in individual or family functioning. The goal of family therapy is to assist families in restoring their developmental momentum so that they can continue to support individual growth as opposed to launching the family to more complex levels of structure.

Breunlin (1988) also views family development as a continuous process. He argues against the notion that changes within stages are of first order and those during transitions are of the second order. Breunlin (1988) considers the distinction between first and second order change "as an artificial and overly constraining way to view the process of change" (p. 139). When applied to the life cycle model, this distinction relegates change during stages to a position of secondary importance. Breunlin (1988) proposes a "theory of oscillation" that accurately reflects family development as a function of time. This theory views change throughout the life cycle and not only at nodal transitions. This change is expressed in terms of competence and can be seen as a swing or "oscillation" between overly competent and overly incompetent behaviour (Breunlin, 1988). Breunlin (1988) "refers to the process by which competence is regulated to a different level through change in a sequence as a microtransition" (p. 143). With the "oscillation" theory, the distinction between stage

and transition becomes less meaningful.

Family development is seen as persistent and important "microtransitions" occurring at all times. "At points of nodal transition, the process is similar but intensified, because the number of microtransitions clustered at a given time is greatly increased" (Breunlin, 1988, p. 143). Microtransitions do not happen in discontinuous leaps. "Instead, a microtransition consists of a period during which both sequences and their associated levels of competence exist simultaneously - in other words, an oscillation exists between the two sequences and the two levels of competence" (Breunlin, 1988, p. 145). The potential for continuous oscillation develops when the microtransitions that regulate competence result in a less-then-competent or a greater-than-competent level. These oscillations are most likely to occur at "nodal transitions" like adolescence because of the large number of microtransitions clustered at such times. "Oscillation theory hypothesizes that symptoms arise as a result of the family's inability to regulate behaviour at an appropriate level of competence" (Breunlin, 1988, p. 150). The task of the family therapist is to "dampen and eliminate the oscillation, thus restoring normal development and eliminating the symptoms" (Breunlin, 1988, p. 150).

While many authors view family development as an often plodding, continuous process, Hoffman (1980), prefers a discontinuous view of family change: "One property that

families share with other complex systems is that they do not change in a smooth, unbroken line but in discontinuous leaps" (1980, p. 92). She believes that changes among "living systems" including families takes the form of a "transformation", a rapid emergence of more "functionally organized patterns that did not exist before" (Hoffman, 1980). "The change in the setting creates a discontinuity because range of behaviours, the 'grammar' for allowable activities, has changed" (Hoffman, 1980, p. 93). New patterns and interactions among family members emerge which are organized in a more complex way than the previous one. This system is also governed by "rules" and will not change again until "new pressures from the field enforce a new leap" (Hoffman, 1988, p. 93). The history of the transformation is as follows:

> First the patterns that have kept the system in a steady state relative to its environment begin to work badly. New conditions arise for which these patterns were not designed. Ad hoc solutions are tried and sometimes work, but usually have to be abandoned. Irritation grows over small but persisting difficulties. The accumulation of dissonance eventually forces the entire system over an edge, into a state of crisis, as the homeostatic tendency brings on ever-intensifying corrective sweeps that get out of control (Hoffman, 1980, p. 56).

Symptoms are the consummation of a series of ad hoc, first-order solutions that keep the family fixed in time (Hoffman, 1980). Therefore, the challenge for the therapist becomes: "How does one interfere with a mechanism that ensures family stability (morphostasis) and instead help the

family achieve a transformation that will represent a more complex integration (morphogenesis)" (Hoffman, 1980, pp. 62 - 63). The solution according to Hoffman (1980), "is through a discontinuous process in which the family takes a leap to an integration that will better deal with the changed field" (1980, p. 56). By this account, a discontinuous leap will tease out the more functional behaviours previously lacking in the system.

A discontinuous model of change is based on the ideas of second-order change, and it clearly shows how a family behaves during the transition process. The clinical implications of this life cycle model are considerable, because conceptually, therapy is organized in such a way as to produce a second-order transformation through a discontinuous leap (Breunlin, 1983). This model also places a lot of emphasis on the use of "paradoxical strategies" as the more desirable form of intervention for producing second-order transformation (Breunlin, 1983).

In family therapy, "there has been a significant movement from a focus on homeostatic processes toward an emphasis on change-promoting processes" (Falicov, 1988, p. 41). The family therapy literature discusses "continuity" and "change" in the systems in a "dualistic" way rather than in a "dialectical" fashion. For instance:

> By assuming that the changes within stages are continuous and of the first order and that the changes between

> stages are discontinuous and of the second order, since these processes are believed to operate separately or at best sequentially (Falicov, 1988, p. 41).

For a family to be both flexible and stable, the tendencies toward change and discontinuity need to co-exist with the tendencies toward continuity and stability (Melitto, 1985).

Functional family development calls for an integration of the two types of processes, so that a sense of continuity, identity, and stability can be maintained while new behavioral patterns are emerging (Falicov, 1988). According to Falicov:

> One way to resolve the tendency to dichotomize and polarize processes that actually flow together is to think of a dynamic balance or ratio between continuous and discontinuous changes at all points in the family life cycle. At times and in some areas, the ratios will change toward more continuity than discontinuity, or vice versa, but one process could never replace the other (Falicov, 1988, p. 41).

Breunlin (1983) states that "The net result is an elegant theory on which are based sophisticated interventions that frequently produce dramatic outcome" (1983, p. 2). Liddle and Saba (1983) offer more specific limitations of this model:

> A discontinuous-only description creates the illusion of specificity (Whitehead's fallacy of misplaced concreteness) regarding the timing of change. How is it possible to be sure that change has occurred precisely at the (apparent) leap of transformation. Such leaps are compelling, dramatic descriptions, but they are weak on explanatory substance (Liddle & Saba, 1983, p. 168).

They also call into question the "all-or-nothing" view that the model encourages to the preclusion of other models, views and ideas.

Carter and McGoldrick (1982) emphasize two cautions about the life cycle perspective. They state that an inflexible adherence to applying psychology to the "normal" life cycle can have counter-productive effects if it causes an undue concern in a person that any change from the norm can cause one to be seen as abnormal (Carter & McGoldrick, 1982). Secondly, they believe placing too great of an emphasis on the uniqueness of a family and the changing would ignore the historical context the family developed and exists in (Carter & McGoldrick, 1982). In working with families, it is essential to understand their developmental context and tasks on which they are presently working. Seeing families in terms of a family life concept reframes their issues as normative extensions of everyday life. Exploration of family symptoms in view of development and unsuccessful transitions is a way to understand the difficulties family members face.

As adolescents begin to move away from parental influence, parents may be struggling with other losses, making the adolescent stage particularly more stressful. The family life concept is helpful for understanding, assessing, and sometimes reframing a family's problem (Liddle & Saba, 1983). In conclusion, one must consider not only the individual developmental stages of each family member but also the

relationship, interconnections and the influences each has on the others (Liddle & Saba, 1983).

The Adolescent Phase of the Family Life Cycle

According to Preto (1988):

> The adaptations in family structure and organization required to handle the tasks of adolescence are so basic that the family itself is transformed from a unit that protects and nurtures young children to one that is a preparation centre for the adolescents' entrance into the world of adult responsibilities and commitment (Preto, 1988, p. 255).

Because this stage often coincides with changes in parents as they enter midlife, and grandparents entering old age, retirement or confronting illness or death, the transition needs extreme shifts in relationship patterns across generational boundaries (Preto, 1988). The major emotional task for the family with adolescents is to accept the need for increasingly flexible boundaries to include children's independence.

The second-order changes that are required for the family to proceed developmentally are: 1) parent-child relationships must shift to permit adolescents to move easily in and out of the family system and; 2) parents need to refocus their attention on midlife marital and career issues (Carter & McGoldrick, 1982).

Adolescents open the family to a whole array of new

values as they bring friends and new ideas into the family system. The family boundaries must be flexible and permeable enough to allow for increased independence, autonomy and responsibility in the adolescent, while maintaining basic issues of trustworthiness, support, and advice. For parents, this also marks the time when they can no longer maintain complete authority. Parents often feel that their existence is being challenged by the adolescent. The challenges associated with the adolescent's search for increased independence and autonomy may conflict with the family's need for stability and continuity.

If parents attempt to control every aspect of the adolescents' lives, they "may inhibit the ability of the adolescent to explore identity-relevant options unfamiliar to his or her family" (Worden, 1991, p. 9). If parental authority or control is relaxed and the family boundaries are too diffused, the adolescent may feel abandoned by his or her family... too much autonomy inhibits identity-relevant exploration and leaves the adolescent without a sense of boundaries or a secure 'home-base' from which to explore (Worden, 1991). On the other hand, if the adolescent is to develop a healthy identity, s/he must be able to question family value systems and boundaries. The family's need for stability, and the adolescent's need for change, challenge the family and the adolescent to "constantly strive for a balance of power that allows for experimentation and yet provides

protection" (Preto & Travis, 1980, p. 26). Parental authority must be relaxed to be able to cope successfully with the adolescent's independence and autonomy.

> Flexible boundaries that allow adolescents to move in and be dependent at times when they cannot handle things alone, and to move out and experiment with increasing degrees of independence when they are ready, put special strains on all family members in their new status with one another (Carter & McGoldrick, 1982, p. 183).

Increased flexibility allows the adolescent to form significant relationships outside the family which is essential for the development of his or her own identity.

In some families, emerging autonomy of the adolescent is threatening for the parents. Parents often say "Where did my little boy and girl go?' In these families, battles rage over the adolescent's choice of music, friends, clothes and activities. What the adolescent finds important for his or her life may contrast greatly with what the parents find meaningful. According to Carter and McGoldrick (1982), "families that become derailed at this stage are frequently stuck in an earlier view of their children" (p. 183). Parents attempt to guide and point out to their adolescent what is important in life and to what he or she should pay attention. More often than not, this advice does not fit the adolescent's experience. As a result, "either the adolescent withdraws from the appropriate involvements for this developmental stage, or the parents become increasingly frustrated with what

they perceive as their own impotence" (Carter & McGoldrick, 1982, p. 183). If parents feel threatened when their adolescence departs from their parental values, they may respond in an authoritarian manner by restricting activities of their adolescents to experiences that are compatible with the parental values. This may have serious implications. If parents insist on continual obedience to their values, the adolescent can either become rebellious or passively give lip service to parental standards. When this happens, the achievement of identity becomes difficult.

At the same time that the adolescent is going through a developmental crisis, the parents face developmental tasks, as well. "Parents may find themselves reassessing their own values, belief systems, and personal styles, partly in response to their adolescent and partly as a result of their own developmental crisis" (Preto & Travis, 1985, p. 24). In most families with adolescents, the parents are moving towards middle age (Preto, 1988). The parents begin to reevaluate their marital and career choices. "Often people at this stage experience an acute dissatisfaction with themselves and their lives and feel compelled to make changes such as marital separations, divorces and career changes" (Preto & Travis, 1985, p. 24). This can be a source of stress in the family, as the parents must come to terms with their unrealized dreams and hopes. Consequently, it is common to see parents and adolescents challenged by similar concerns (Preto & Travis,

1985). "Both may be struggling with personal goals and relationships as well as grappling with issues of autonomy and individuation" (Preto & Travis, 1985, p. 24).

The additional stress of an adolescent questioning parental authority, challenging family rules, and becoming sexual, can identify the adolescent as the problem in the family for the parents. It is these families, who seek help either voluntarily or through referral by others to cope with the stress of the transition of adolescence and its accompanying changes in family relationships and structures, that the therapist wants to help. Carter and McGoldrick (1988), who discussed the overall transformation that families face as they try to manage the tasks of adolescence, concluded that:

> Often families continue trying solutions that are ineffective in helping them meet the demands of adolescence. Unable to make the necessary shifts that facilitate growth, they become stuck, repeating dysfunctional patterns that eventually lead to symptomatic behaviour in adolescents. Helping these families find solutions that may break those cycles by precipitating a second-order change is a primary goal of therapy (Carter & McGoldrick, 1988, p. 271).

In summary, as families move from one life stage of development to the next, they can experience stress, some conflict, and confusion because the family system is in disequilibrium and transition. Because the changes in relationships are negotiated over time, "periods of

disequilibrium result before the family system has fully adapted to changes in its members" (Steinberg, 1987, p. 84). These stages may show "not-yet-completed relational transformations" (Steinberg, 1987, p. 84). Therefore, "it is easy to mistake these times of disequilibrium for periods of conflict" (Steinberg, 1987, p. 84). It is important for the therapist to be aware of the developmental stages of the family and the individual members, and focus on the many ways parents and their adolescents may be struggling over similar issues regarding relationships and personal goals (Preto & Travis, 1985). Therefore, a therapist must assess whether a family is undergoing a developmental impasse or a more serious problem.

CHAPTER TWO

CLINICAL MODELS OF INTERVENTION

Introduction

When a family comes for therapy with an adolescent, there are at least two ways of looking at the problem. The problem can be seen as the adolescent encountering difficulty resolving the developmental tasks. From such a view, the adolescent could be seen alone in order to help him or her resolve these issues. This often appeals to other family members because it re-enforces their perception of the problem, and it is a less stressful process than meeting with the whole family and facing the anger and conflict that are often present in family sessions where an adolescent is the identified problem.

If one views the problem from a family systems perspective, one sees the adolescent and the problem as a symptom of a family undergoing stress and conflict. From this perspective, the adolescent's symptoms are assessed in light of developmental dynamics and are then placed within the family context. Therefore, the therapist can determine whether the family is having difficulty making a transition to a new stage of development, or that family development is arrested.

To assess family problems fully, one must not only look

at the family in relation to predictable family crises and to the developmental history of that particular family, but one must also look at the relationships in the family system as evaluated against the developmental backdrop (Fishman, 1988). Within the structural model, the problem is viewed as part of the family structure of transactions. Like most systems approaches, the structural model regards the psychological structure of the individual as interdependent with his/her social structure. The social structure is considered fundamental to the socialization of the individual is the family. The family is the medium through which the individual functions and expresses him/herself. As a result, the role of the therapist is to assess the underlying systemic structure that maintains the problem and develop a solution to that problem.

Identifying the organizational problem is essential to determining the solution in the structural model. However, it has been suggested by de Shazer and colleagues (1990) that solutions can be promoted by focusing therapy sessions on activities that centre around finding solutions. This approach, rather than trying to fix what is not working, aims to enhance those behaviours that are already positive and functional. Therefore, the solution focused brief therapy approach focuses on solutions, not on problems. Therapists get clients to concentrate on solutions that have worked. The orientation toward solutions "is an attempt to create an

atmosphere in which people's strengths can move out of the shadows and into the foreground" (Nichols & Schwartz, 1995, p. 447). de Shazer (1986) found these strengths hiding in the spaces between problems - in the "behaviours, perceptions, thoughts, feelings and exceptions that are outside the complaint's constraints" (cited in Nichols & Schwartz, 1995, p. 447). "These exceptions... can be used as building blocks in the construction of a solution... solutions involve determining what 'works' so that clients can do more of it" (Nichols & Schwartz, 1995, p. 447).

In this section of the practicum report, I briefly introduce the two models of therapy. The first model is based on Minuchin's work which is the structural family therapy approach. This model was used to assess how the family structure functioned. The second model is one developed by de Shazer and the Milwaukee Brief Family Treatment Centre. This approach was utilized to intervene with a family system. Specifically, treatment focused on what the family was doing that was already working, based on the assessment of the family structures that were already functioning adequately.

This practicum used a family therapy approach which utilized both structural and solution focused frameworks, which falls under the category of strategic family therapy. It also examined how these two approaches could be integrated conceptually. Presently, there are mixed feelings in the family therapy field as to whether or not it is reasonable to

integrate the two models (Fish & Piercy, 1987). Family theoreticians agree that while integrated approaches expand the therapist's conceptual base and technical tools available to him/her, integration should be based on a clear understanding of the assumptions and conceptual basis of each approach (Sluzki, 1983). The following section examines the conceptual foundations of each model in detail.

The Structural Model - Conceptual Foundations

The structural model of family therapy was developed by Salvador Minuchin (1974). He states that structural family therapy is:

> ...a body of theory and techniques that approaches the individual in his social context. Therapy based on this framework is directed toward changing the organization of the family. When the structure of the family group is transformed, the positions of members in that group are altered accordingly. As a result, each individual's experiences change (Minuchin, 1974, p. 2).

The organization of the family for the functioning of the family unit and the well-being of its members is of key importance to Minuchin. Structural family therapy views the family "as a living organism, constantly developing and adapting to a changing environment - an open sociocultural system in transformation" (Minuchin, 1974, p. 51). One implication of the 'organismic view of families' is a sense of

acceptance of and regard for different forms of family life, and a broad description of normal family functioning (Colapinto, 1991). Minuchin (1974) directly addresses the issue of normality, "contending that a normal, ordinary family cannot be distinguished from an abnormal family by the absence of problems" (Walsh, 1982, p. 11). He goes on to say that "the myth of 'placid' normality - the prevailing idealized view of the normal family as non-stressful, living in constant harmony and co-operation, while coping with social input without upset" is an idealized myth (Walsh, 1982, p. 11). Normal families are constantly struggling with problems of living.

Minuchin (1974) views the family as a social system, functioning within a specific social context. According to Walsh (1982), the family system has three elements. Firstly, the structure of the family is regarded to be an "open sociocultural system in transformation" (p. 12). Secondly, all families undergo normal transitional steps or stages over time that require restructuring or modifying the structure of the family to accommodate to changed circumstances. Thirdly, the family will continually adapt to its changing needs in order to enhance the "psychosocial growth and change of its members through time" (Walsh, 1982, p. 12).

Minuchin (1974) refers to the concepts of structure, subsystems, boundaries and hierarchies as essential to assess family functioning. He describes "family structure as an

invisible set of functional demands that organize the ways in which family members interact" (Minuchin, 1974, p. 51). This structure provides the day-to-day patterns through which the family members carry out their relationship in accordance with the requirements of each function. These repeated patterns or transactions determine how, when and to whom family members relate. Family structure is controlled partly by universal rules and in part by 'idiosyncratic' constraints. "All families have some kind of hierarchical structure, with parents and children having different amounts of authority" (Nichols & Schwartz, 1995, p. 213).

Reciprocal and complementary roles also direct these family relationships. Transactional patterns support mutual expectations that govern future patterns in families (Nichols & Schwartz, 1995). These expectations develop over years through 'explicit and implicit negotiations' between family members, and family members are often aware of their role in negotiating or maintaining these constraints. Therefore, these patterns of interactions among family members are "presumed necessary rather than optional" (Nichols & Schwartz, 1995, p. 213).

As stated earlier, the family system employs generic and idiosyncratic constraints in order to maintain itself and to regulate change. These preferred patterns tend to be "self-perpetuating and resistant to change" (Nichols & Schwartz, 1995, p. 213). Although alternative patterns are available

within the family system, "families are unlikely to consider them until changing circumstances produce stress and dysfunction in the system" (Nichols & Schwartz, 1995, p. 213). Most families manage transitions or changes with only temporary and moderate stress. "The more rigid the patterns of interaction, the more stressed families will be by the need to develop for change, and the more likely they will be to develop symptoms" (Waditel & Waditel, 1986, p. 60). Minuchin (1974) suggests:

> That the stress associated with normative and transitional changes within the family life cycle represents one form of stress encountered by families. Stress may also come from the contact of one family member with extrafamilial forces, the contact of the whole family with similar forces and stresses around specific and idiosyncratic problems (Minuchin, 1974, p. 61).

These changes in the family system force family members to develop new patterns and skills to accommodate to changed circumstances.

Structural therapists identify three subsystems within the family. These are: the spouse or marital subsystem, the parental subsystem and the sibling subsystem. Each subsystem has specific functions and makes specific demands on its members and each subsystem is set apart by boundaries which determine who will participate within it and the conditions which apply (Minuchin, 1974). The composition of subsystems organized around family functions is not nearly as significant

as the clarity of subsystem boundaries. According to Minuchin (1974):

> For proper family functioning, the boundaries of subsystems must be clear. They must be defined well enough to allow subsystem members to carry out their functions without undue interference, but they must allow contact between the members of the subsystem and others (Minuchin, 1974, p. 54).

Minuchin (1974) suggests that the clarity of boundaries within a family system is a good measure of family functioning. He also identifies rigid and diffuse interpersonal boundaries at either end of a continuum. Minuchin (1974) notes that the various boundaries actually refer to specific transactional styles within the family system and most families demonstrate enmeshed and disengaged styles at different times.

According to Walsh (1982), "in an enmeshment family pattern, differentiation among members is blurred, distance is decreased, and the sense of belonging interferes with autonomy, problem mastery and cognitive-affective skills" (p. 12). This kind of system may become overloaded and lack the resources to accommodate and change. At the other end of the continuum, "...disengaged family pattern, rigid boundaries impede communication and the protective functions of the family, as individual members' autonomy is achieved at the expense of relatedness and of response to one another" (Walsh, 1982, pp. 12 - 13). This disengaged style may contribute to

a skewed sense of independence, growth and mastery and fail to promote an appropriate level of interdependence and loyalty among family members (Walsh, 1982). According to Minuchin (1974), "these families often tolerate a wide and varied range of individual behaviour and they fail to respond appropriately in situations which require intervention and support" (p. 55).

The primary task of a family system is to change in order to accommodate the growth and the changing needs of family members as it fosters a sense of loyalty and belonging (Minuchin & Fishman, 1981, p. 11). In the process, the family structure changes, "boundaries are redrawn, subsystems regroup, and hierarchial arrangements shift" (Colapinto, 1991, p. 424). As a result, children require different styles of parenting at different ages. For example, during the adolescent stage, boundaries must become more permeable and parental authority must change as the adolescent develops contacts outside of the family and attempts to clarify his/her identity. "Issues of autonomy and control must be renegotiated at all levels" (Minuchin, 1981, p. 25).

Excessively rigid and impermeable boundaries that are maintained over time can impair the growth and development of individual family members. All or most families face situations that stress the family system. According to Nichols and Schwartz (1995), "although no clear dividing line exists between normal and abnormal families, we can say that normal families modify their structure to accommodate to

changed circumstances; pathological families increase the rigidity of structures that are no longer functional" (p. 218).

According to Minuchin (1974), "the hierarchical arrangement of a family is expressed by rules that prescribe differential degrees of decision-making power for various individuals and subsystems" (cited in Colapinto, 1991, p. 424). In a well functioning family, "the parents are hierarchically positioned above their children - they are 'in charge', not in the sense of arbitrary authoritarianism, but in the sense of leadership and protection" (Colapinto, 1991, p. 424). In many respects, families need structure, parental teamwork, and differentiation between subsystems for healthy family functioning.

The terms coalition, detours, triangulation and alliances are additional concepts that Minuchin (1974) describes in his work with families. A coalition develops when two family members join together against a third. Minuchin (1974) describes coalitions, whether cross-generational or not, as indicative of underlying systemic conflicts which create and bring about family problems. Alliances are teaming-up of two parties based on common interests with no third party involved. Detours and triangulations are identified by Minuchin (1974) as conflict-avoidance patterns of involvement between family members. This is a common way for families to express their fear of change. Family members are hesitant to

directly address their disagreements to protect themselves and each other from telling the truth. According to Nichols and Schwartz (1995):

> A common expression of conflict-avoidance between partners involves diverting conflict to the children, in which case conflicts between the spouses are played-out in the parenting battlefield - and that as they pull in different directions, the confused children become casualties (Nichols & Schwartz, 1995, p. 219).

Triangulations occur when the child is openly pressured to become an ally with one parent against the other parent. The conflict between the parents gets redirected onto a child. Instead of worrying about each other, they worry about the child. "Although this reduces the strain on the father and mother, it victimizes the child and is therefore dysfunctional" (Nichols & Schwartz, 1995, p. 219).

Structural family therapy offers the therapist concrete tools in order to map the family's organization and structure. This map will guide the therapeutic intervention. According to Minuchin and Fishman (1981):

> The family map indicates the position of family members vis-a-vis one another. It reveals coalitions, affiliations, explicit and implicit conflicts, and the ways family members group themselves in conflict resolution. It identifies family members who function as switchboards. The map charts the nurtures, healers and scapegoaters. Its delineation of the boundaries between subsystems indicates what movement there is and suggests possible areas of strength or dysfunction (Minuchin & Fishman, 1981, p. 69).

Structural family therapists typically employ three strategies and a variety of techniques in order to promote change. The three strategies are challenging the family structure, challenging the symptom, and challenging the family's world view or reality (Minuchin & Fishman, 1981).

Minuchin (1974) believes that problems in families are supported by dysfunctional family structures. Therefore, intervention is directed at challenging the family structure of transactions to promote change in the family system. "By altering boundaries and realigning subsystems, the therapist changes the behaviour and experience of each of the family members" (Nichols & Schwartz, 1995, p. 224). It is the family's job to solve their problems, not the therapist's. The structural therapist challenges and assists family members to modify their family functioning so that problems can be resolved. According to Nichols and Schwartz (1995), "...symptom-resolution is sought not as an end in itself, but as a result of lasting structural change" (p. 224). The structural therapist may also challenge the symptom by asserting that the problem resides within the family and not the adolescent. The challenge may be "explicit or implicit, straightforward or paradoxical" (Minuchin & Fishman, 1981). "The goal is to change or reframe the family's view of the problem, pushing its members to search for alternative behavioral, cognitive affective responses" (Minuchin & Fishman, 1981, p. 68).

Finally, the structural therapist may also attempt to challenge the family's reality since the family's view has sustained the symptom in an intentional or unintentional manner.

> The therapist takes the data that the family offers and reorganizes it. The conflictual and stereotyped reality of the family is given a new framing. As the family members experience themselves and one another differently, new possibilities appear (Minuchin & Fishman, 1981, p. 71).

As new possibilities emerge, the family is often able to utilize its own resources and make necessary changes. The techniques employed in this strategy may emphasize family strengths, cognitive constructs and paradoxical interventions. This approach is congruent with the brief therapy approach, which builds on the client's strengths.

In summary, structural family therapy takes into account the individual, family, and social context, and provides a clear organizing framework for understanding and treating families (Nichols & Schwartz, 1995). It also offers the therapist concrete tools with which to assess family functioning, and for determining the underlying systemic structure that produced the symptom.

Critics of the structural family therapy model note that structural family therapists work with what they see going on in the session, not what family members describe about what happens outside of the sessions. Thus, unless the behaviour

is seen or discussed during the session, it may not be addressed. The therapist is more interested in what is to be solved than in what is wrong. The model also requires the presence of the whole family in order for the therapist to make an accurate assessment of family functioning. The structural approach is more a theory of the family than a theory of change, and does not include a "comprehensive theory" of dealing with "resistance". According to Hoffman (1981):

> It is a genuine limitation that although Minuchin's theory is most eloquent about family systems and family structure, it does not contain a comprehensive enough theory of change to cover the area misnamed 'resistance', and the moves which deal most successfully with it (Hoffman, 1981, p. 270).

The structural model requires a therapist who can generate and tolerate high levels of affective intensity, and who is comfortable with an active and directive therapeutic style. That is, the structural therapist may adopt a wide range of therapeutic postures, ranging from confrontational to curious, but s/he is generally in a one-up position with respect to the family.

According to feminist critics, this therapeutic style can, at times, be problematic. For example, "the forceful manner of a powerful male therapist may be confused as a requisite of the model and viewed as a necessary therapeutic stance for the approach to be effective" (Walsh & Scheinkman,

1989, p. 28). Therapists need to be sensitive to the experiences of a female who has been in "subordinate" positions to the men in her work and family life (Walsh & Scheinkman, 1989). "Despite her apparent compliance, she is likely to feel intimidated or patronized by an overpowering male therapist" (Walsh & Scheinkman, 1989, p. 28). The therapist can promote structural changes by using himself/herself in ways that are respectful, sensitive and validating to all family members. The therapist's interventions should not reinforce the woman's one-down position.

Critics also note some cautions in relation to the concepts of hierarchy and boundaries. Walters, Carter, Papp and Silverstein (1988) discuss how the definition of appropriate boundaries is based on the male model of closeness and distance in relationships. This concept disregards female styles of interaction and understandings of relatedness. The concepts of hierarchy and subsystems have also been based on a traditional, two-parent family model (Goodrich, Rampage, Ellman & Halstead, 1988). This view places a single-parent family at a disadvantage. Minuchin (1976) attempted to pay attention to the power differential in the hierarchy between generations as a "universal feature" in the family systems and focused intervention on "structural rebalancing" as a main objective of family therapy (Walsh & Scheinkman, 1989). However, the hierarchial imbalance between husband and wife

has yet to be addressed in therapy. "Given the differential of power and status between men and women in society that frames all family interaction, it is a fallacy to assume that a power balance is maintained in family systems, with each member having equal influence" (Walsh & Scheinkman, 1989, p. 38). Lastly, feminist critics acknowledge that the structural model of family therapy does not deal adequately with the social pressures and constraints that society places on a husband's or a wife's position. For example:

> A sense of powerlessness and failure in meeting standards for job success and financial provision to his family may contribute to a father's unavailability and frustration, which may be expressed in neglect or abuse of his wife or children (Walsh & Scheinkman, 1989, p. 28).

The structural model of family therapy poorly addresses the family in its larger social, economic and political context. In overlooking these contexts, the danger for the therapist using this model is a tendency to assess the family's structure as dysfunctional, when in fact, the larger culture supports its organization.

Outcome Studies

The efficacy of structural family therapy for certain well-defined clinical problems has been noted in reviews of the family therapy outcome literature. In one of the earliest

reports, Minuchin and his colleagues (1967) examined the effectiveness of structural family therapy among twelve families of low socioeconomic status that identified delinquency and aggression as problems in their families. Since no control group was used in this study, it is difficult to evaluate the relative effectiveness of the treatment. However, the authors reported significant improvement in seven out of twelve client families in the area of family functioning and relationships.

Later studies conducted by Minuchin and his colleagues (1967) reported significant improvement in individual and family functioning when structural family therapy was applied to the treatment of childhood and adolescent psychosomatic symptoms such as anorexia, asthma and psychogenic pain. In their review of the outcome research prior to 1980, Gurman and Kniskern (1981) concluded that structural family therapy "should be considered as a treatment of choice" for children and adolescents who have "psychosomatic conditions".

Minuchin, Rosman and Baker (1978) summarized the results of treating fifty-three cases of anorexia nervosa with structural family therapy. At the end of treatment and follow-up, almost all of the symptomatic children had "improved greatly" in relation to symptomatic and psychological behaviours. Deterioration or re-hospitalization of patients was rare. Unfortunately, no control group was used. However, even with this limitation, structural family

therapy has been shown to be effective in treating psychosomatic families.

Gurman and Kniskern (1981) suggest that the results are not as conclusive with drug-addicted families. They report a number of shortcomings which characterize the outcome research with this group. These are: 1) incongruity between treatment techniques, 2) no control group, and 3) use of inadequate measures. However, they suggest that tentative conclusions are possible and they report that structural interventions are "at least as successful as any of the current schools" and they appear to be effective in at least 50% of the cases in the outcome studies which they have examined (p. 358). These findings have been supported in more recent reviews of the outcome literature for family therapy. Tolan, Cromwell and Brasswell (1986) report "sound evidence" for the structural family therapy model's viability with delinquent youth and their families. However, they suggest that more specific and robust evidence is still required (p. 619). The outcome research did support the relationship between family functioning and delinquency. Breunlin, Breunlin, Kearns and Russell (1988) note that family therapy has become a common treatment modality when families identify concerns about an adolescent member. They suggest that the outcome research which they reviewed supports the use of structural family therapy for these families.

Solution Focused Brief Therapy Approach - Conceptual Foundations

Solution focused brief therapy model is heavily based on the therapeutic ideas of Milton Erickson. More specifically, this model is closely linked with the strategic family therapy approach. Haley (1987) defined strategic therapy as follows:

> Therapy can be called strategic if the clinician initiates what happens during the therapy and designs a particular approach for each problem... [the therapist] must identify solvable problems, set goals, design interventions to achieve those goals, examine the responses he receives to correct his approach, and ultimately examine the outcome of his therapy to see if it has been effective (cited in Cade & O'Hanlon, 1993, p. 4).

Fish and Piercy (1987) have developed a profile of strategic therapy based on a consensus of opinion from 18 strategic therapists. According to their study, the strategic model is based on the assumption that problems evolve and are maintained through current behaviours and our relational interaction with others. Patterns of interaction becomes recursive, thereby repeating the problematic behaviour in a vicious cycle. The problem is maintained by people struggling with the wrong solutions or no solutions.

Furthermore, through redefinition of behaviours, positive shifts may take place in the feelings, attitudes, and interactions of relationships. A change in the meaning that

clients associate with the problem can lead to solutions.

More recently, de Shazer and his colleagues at the Brief Family Therapy Centre in Milwaukee developed a solution focused brief therapy approach which was based on Erickson's ideas about people's resources and strengths. The solution focused brief therapy model is also closely related to the brief problem focused therapy model developed at the Mental Research Institute (M.R.I.). In this model, the goal is to identify the problem. According to Haley (1987), problems are assumed to be maintained by repeated interactional patterns. Once a problem has been identified, a solution can be developed to break the pattern and meet the goal of therapy, which is, the extinction of the problem (Haley, 1987). However, de Shazer (1988) notes that in this model, knowing the details of the problem or the complaint is necessary prior to finding solutions to the complaint.

Recently, de Shazer has moved away from this tradition and suggested a clinical focus on identifying solutions rather than problems (de Shazer, 1982, 1985, 1988, 1991; de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich & Weiner-Davis, 1986). According to de Shazer (1988), the model is built on the assumption that "the client constructs his or her own solution based on his or her own resources and successes" (p. 50). These resources may be life experiences, world views, language, relationships, and past success in dealing with problems. Solution focused brief therapists maintain that

therapists do not need to know a great deal about the nature of the problem in order to solve it. Instead, it assumes "whatever the cause of a problem might be, its continuation has something to do with the context or setting in which it occurs and the expectation that the problem is going to continue" (de Shazer, 1988, p. 58). Therefore, the focus is situation-centred rather than family or person centred.

> In order to construct solutions, it can be helpful to find out as much as possible about the constraints of the complaint situation and the interaction involved, because the solution needs to 'fit' within the constraints of that situation in such a way as to allow a solution to develop (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986, p. 208).

According to de Shazer (1985):

> The interventions... are designed to set up situations in which the family spontaneously behaves differently. They are based on the pattern data the family offers... and presented in terms consistent with the family's world view as perceived by the therapist. Although he instructs the client to perform a task, the therapist often has no more idea than the family what specific spontaneous behaviour the family may develop in the process of carrying out his instructions... The immediate goal is to set up a task that... puts the family in a situation in which different behaviour is a must (de Shazer, 1985, p. 8).

The intervention, therefore, need only prompt the initiation of some new behaviour patterns (de Shazer, 1985). de Shazer (1985) makes some assumptions about the construction of complaints. These assumptions assist the therapist in the

construction of solutions. The first assumption is that "complaints involve behaviour brought about by the client's world view" (de Shazer, 1985, p. 23). People behave in a certain way because of their world view. They tend to assume that what they are doing is in response to their problem is the only logical and correct thing to do. Therefore, the complaints continue to be maintained by the client's limited view of the choices available to them.

The second assumption is based on the idea that people will continue to follow the same behaviour over and over again because they have used up their repertoire of available responses to the complaint. As a result, people will continue to respond to the same complaints in the same ineffective fashion. This form of interaction in a family unit creates an unhelpful pattern. These assumptions allow therapists to draw maps of clients' complaints in such a way that solutions to the complaints can be found. Conceptual maps tell us how to construct problems and how to get to the solutions. It is the foundation of our understanding about what is happening in the therapy situation.

In the therapeutic process, the therapist makes two maps: one map is the client's description of the problem; the second map is of how the therapist sees the client's explanation of the complaint. The variation between the two maps presents the therapist with information which may lead to a solution and presents the framework for designing the intervention.

"It is the fit between the therapist's description of the complaint pattern and form and the maps of the intervention which seems central to the process of initiating therapeutic change" (de Shazer, 1985, p. 60). That is, the therapist constructs the complaints and potential solutions out of the same information as the client but with focus on solutions. According to de Shazer (1985), "The intervention (regardless of the design principles involved) simply needs to fit within the client's pattern (as mapped by the therapist) in such a way that the map points the way out of the oscillation" (p. 61). Therefore, the use of maps assists the therapist in the development of the concept of fit, which is more general and flexible (de Shazer, 1985). "There is no need to attempt to understand the lock in order to build an effective key when a skeleton key may work as well" (de Shazer, 1985, p. 61).

Given the complexity of complaint constructions, it would seem reasonable that solutions would need to match that complexity. However, "the interventions and the solutions only need to fit within the 'constraints of the complaint' in much the same way that a skeleton key fits within the constraints of may different locks" (de Shazer et. al., 1986, p. 212). Moreover, the clients seem to hold the key to solutions much more than the therapist, and therefore, the purpose of both interview and solution is to help the clients find that key. According to Lipchik (1993), "a solution must have a unique fit for individuals in the it must represent a

balance of good and bad that is acceptable to them at a particular time and in a particular situation" (p. 26). When people do something different, it will be something that fits for them and not something specific suggested by the therapist that might seem outside the bounds of possibility for their system. The concept of fit also deals with the relationship between therapist and the client(s) and "involves a special kind of closeness, responsiveness, or harmony" (de Shazer, 1988, p. 90). "When a fit is established, all the participants pay close attention to what others are saying" (de Shazer, 1988, p. 90).

The solution focused model is based on other assumptions that guide the therapist's thinking and offers therapists a new lens for viewing clients. Each of the assumptions promote and reinforce the therapist's belief in the client's health and ability to move in positive directions. In this practicum report, I will describe seven core assumptions which guided my work with adolescents and their families. After presenting the seven assumptions below, I will briefly discuss each theoretical concept. The core assumptions are:

1. Resistance is not a useful concept. Solution oriented therapists assume that clients really do want to change. Co-operation is assumed.
2. Only a small change is necessary to generate solutions through the 'ripple effect' (complex problems do not require complex solutions).

3. Clients have resources and strengths to solve problems. They are the experts. The therapist's job is to promote utilization of these resources.
4. Understanding the exact nature of the complaint and its origin is not necessary to generate solutions.
5. Problems are unsuccessful attempts to resolve difficulties. Avoid doing more of the same.
6. Clients define the goals for treatment.
7. A change or shift in the perception or meaning that clients associate with the problem can lead to solutions. (Walter & Peller, 1992, de Shazer, 1985, 1988, 1991).

Resistance implies that clients do not want to change and the therapist is separate from the client system that s/he is treating (de Shazer, 1984). de Shazer (1984) has convinced therapists to approach clients from a position of therapist-client co-operation, rather than focusing on resistance, power and control. According to de Shazer (1985):

> Each family shows a unique way of attempting to co-operate and the therapist's job becomes, first, to describe that particular manner to himself that the family shows and, then, to co-operate with the family's way and thus, to promote change (de Shazer, 1985, pp. 9 - 10).

It is the therapist's responsibility to maintain a co-operative therapeutic relationship with clients. As a way of promoting co-operation, the following approach is recommended:

> First, we connect the present to the future (ignoring the past), then we compliment the clients on what they are already doing that is useful and/or good for them, and then - once they know we are on their side - we can make a suggestion for something new that they might do which is, or at least might be, good for them (de Shazer, 1985, p. 15).

The solution focused approach also assumes that only a small change is required. The belief is that "all parts of a family system are interconnected in such a way that a small change in one part of the system can ripple and cause changes in the other parts" (Selekman, 1993, p. 32). The model supports the concept of working with only one part of the system. de Shazer (1988) suggests that it is more advantageous to only ask those persons to therapy who are most concerned by the problem, as they are seen to be determined to find a solution. According to de Shazer (1985), "since only a small change is necessary to initiate change in the system, the number of people who are in on successfully constructing the problem and the solution does not matter. For brief therapists, their 'patient' is the problem" (p. 17).

The third assumption suggests that people possess certain strengths and resources that can be utilized by therapists to co-construct solutions. Over the course of therapy, solution-oriented therapists work to help clients shift from a preoccupation with problems to a focus on thoughts, feelings and behaviours associated with problem resolution. Selekman (1993) notes that "clients are more likely to change in a

therapeutic context that supports their strengths and resourcefulness than in one that focuses on problems and pathology" (p. 140).

The fourth assumption believes that in every client problem pattern, there are usually some sort of exceptions to the rule when the problem does not occur (de Shazer, 1985). These exceptional thoughts and non-problem patterns of behaviour can be utilized as "building blocks toward constructing solutions" (de Shazer, 1985). de Shazer and his colleagues state that this is a key characteristic of a solution focused interview, and that more often than not, exceptions can be found (Berg, 1990, de Shazer, 1985, 1988, Molnar & de Shazer, 1987). Parents do not experience difficulties with their adolescents all the time. There are hours, days, weeks and sometimes months when their adolescents are not acting out, using drugs or alcohol. Questions such as 'What are their adolescents doing differently during those times?' can effectively bring out from parents a new construction of their problem situation, which can lead to "news of a difference, that makes a difference" (Selekman, 1993). Therefore, if the problem is not always happening, it is not really a problem, and a new future reality is possible (de Shazer, 1990).

The fifth assumption suggests that the client's attempted solutions are the problem. Most families range of response to certain situations is guided by what they think is correct,

moral or logical. As a result, various attempted solutions are applied (which can sometimes include under-reaction and denial) which either have little or no effect or instead, can aggravate the situation (Cade and O'Hanlon, 1993). As Cade and O'Hanlon (1993) describe:

> A problem then becomes entrenched as more of the same solutions, or classes of solutions, became followed by more of the same problem, attracting more of the same attempted solutions, etc. A vicious cycle develops and the continued application of 'wrong' or inappropriate solutions that lock the difficulty into a self-reinforcing, self-maintaining pattern can be seen as becoming the problem (Cade & O'Hanlon, 1993, pp. 78 - 79).

Clearly, it is not always easy to influence people to stop applying their attempted solutions, to try less of the same. This happens because solutions are often associated with strong emotions that have been produced by the problem or a person involved in the problem. Also, these solutions have worked at other times and in different circumstances. Therefore, the more a person invests in a particular position, the harder it becomes to give up that position.

According to Cade and O'Hanlon (1993):

> ... as long as people feel respected and that their concerns have been heard and validated, it is our experience that they are frequently prepared, albeit sometimes cautiously, to attempt to stop doing what is quite clearly not working for them - to do less of the same (Cade & O'Hanlon, 1993, p. 80).

Solution-oriented therapists do not believe that there is any single correct or valid way to live one's life. What is unacceptable behaviour in one family or for one person is desirable behaviour in another. Therefore, clients, not therapists, identify goals to be accomplished in treatment. In therapy sessions, the therapist assists the client in identifying small, realistic and achievable goals. The goals have to be concrete and behavioral in order to construct solutions. de Shazer (1988) states that "the therapist's direct focus on solutions enables clients to talk directly about their complaints as they talk directly about solutions and potential solutions" (p. 54).

The last assumption states that for every event that happens in the world, there are at least two or more explanations of that event. That is, there is no final explanations of reality and that our views of the world are constructed and based on our own perceptions that are familiar to us (Selekman, 1993).

de Shazer (1988) sees the interview process as a "construction or depiction of the client's 'problem', the purpose of which is to bring about change in the situation the client depicts" (p. 77). This process is shaped interactively by the conversation between the client and the therapist and it is this depiction or construction that therapy deals with. Therefore, the purpose of the interview is to help clients change their way of constructing their (problematic)

experience (de Shazer, 1988). "This view assumes that a change in the way clients construct their experience as reflected in how they report it or talk about it, will promote their having a different experience which, in turn, will prompt different depictions or reports in subsequent sessions" (de Shazer, 1988, p. 77). The purpose of the initial interview is to establish rapport or fit between client and therapist, assessing customership, positive focusing towards solutions (searching for exceptions), and setting goals (de Shazer, 1988, Lipchik and de Shazer, 1986). Each therapeutic activity will be discussed separately.

According to Lipchik and de Shazer (1986), "building rapport is the process which creates a workable, task-focused and collaborative therapeutic suprasystem including the family system and the therapist/team system for the duration of therapy" (p. 92). The therapist is responsible for developing and maintaining rapport during the therapy session. It is also the therapist's duty to be developing a 'fit' with the person or persons s/he is interviewing. When 'fit' is established in a session, clients are more likely to be open to developing solutions to their complaint. "By accepting the client's world view, the therapist is able to be useful and help resolve the complaint as simply and easily as possible" (de Shazer, 1988, p. 90).

The solution focused model stresses the initial support of a client's position and world view. It also emphasizes

that people are different in their emotional responses to their problems, different in the way they process information, and different in their world views in which their thinking and acting takes place (Walter & Peller, 1992). Therefore, to maintain rapport with different clients, the therapist must "match and pace their unique way of thinking and feeling" (Walter & Peller, 1992). The technique for doing this is to use the client's language, their key words they frequently use to communicate their thinking and their emotional reaction to their situation (Walter & Peller, 1992). Solution focused therapists accept that people are more likely to become flexible about their beliefs and actions, when they feel that their beliefs and feelings are understood, acknowledged and respected by the therapist.

de Shazer (1988) has developed a practical and useful therapeutic guide for assessing who in the client system is most motivated to work with the therapist in resolving the presenting problem. He has identified the following three different therapist-client relationship pattern: 'visitors', 'complainants', 'customers'. These relationship patterns are not fixed, but change as the solution focused therapist develops 'fit' and a co-operative working relationship with the family. A visitor relationship exists when the client is ordered or referred to therapy by a probation officer, a school teacher, parent, or a judge against their will. In this situation, the client has no complaints and is often

unmotivated to talk in the therapy session about the problem. Therefore, any attempt at intervention is likely to be futile and could lead to a 'resistant relationship' between the 'visitor' and the other people in the office. de Shazer (1988) suggests that in such situations, the therapist should be respectful of what the 'visitor' is saying, compliment where possible, but offer no suggestions or tasks.

Most families with a difficult adolescent can be referred to as 'visitors to therapy' because the adolescent is often directed to come to therapy by their parents, probation officer or judge against their will. Selekman (1993) suggests two useful questions to ask "visiting families" which helps clarify the referral process and maintain "therapeutic manoeuvre-ability" early on in the first interview (p. 49). These questions are: "what do you think gave (the referring person) the idea that you needed to go for counselling?"; "what do you think (the referring person) needs to see happen in counselling that would convince (him or her) that you would not have to come here anymore?" (p. 49). He also describes three therapeutic strategies that he finds useful with 'visitors'. These are:

1. The brief therapist empathizing with the adolescent about being forced or coerced into therapy;
2. Accepting the goals they may have for themselves;
3. The 'Columbo' approach which helps the therapist to be strategic with difficult adolescent 'visitors' (Selekman, 1993).

Walter and Peller (1992) also address this issue of involuntary clients. First they assess the client's clarity and understanding regarding the goals of the referring resource. If the client is unclear, s/he is asked to go to the referring person to find out what the referring person wants as a result of completing therapy. The referring person must be very specific about his or her goals for the client. If these goals are unacceptable for the client, the consequences of ignoring them is explored by the therapist. Other goals clients may identify for therapy are explored and encouraged. If the client is aware of the demands and consequences of not following through with the goals of the referring source, and is still not interested in therapy, they are complimented and the sessions are discontinued. They also suggest that if a therapist has no choice but to continue to see the person because of the requirements of the situation, the therapist must let the client know and continue appointments without trying to solve a problem. By defining the issues clearly and honestly, it demonstrates both client respect and "efficiency regarding the execution of responsibilities to the referral source" (Walter & Peller, 1992).

Cade and O'Hanlon (1993) caution therapists against adopting a "social control stance" when working with clients who have been directed by persons or agencies with the power to attach consequences to non-compliance, such as courts,

child welfare agencies and probation officers. They feel that "when a social control position is adopted, it is clearly either the therapist, or some party or power that the therapist represents, who is the customer for something to happen" (p. 68). In their experience, "people do not change except in ways they themselves are customers for" (Cade & O'Hanlon, 1993, pp. 68 - 69). In addition, when a "visitor" is "forced" to take the customer role, especially where the therapist has sanctions that s/he can bring into action for non-compliance, the therapist is essentially seeking obedience from the client (Cade & O'Hanlon, 1993). In some circumstances, the therapist may not have any other options, however, the social control function or role should never be confused with therapy.

Complainants are clients who attend therapy with a problem or a complaint. They can be a parent, school official, or some social control agent. Often they are very concerned about some aspect of the adolescent's behaviour, and even have some ideas regarding how and what would be different if solved. However, they do not include themselves as part of the solution process.

With difficult adolescent cases, the complaining parent wants the therapist to 'fix' his or her son or daughter through individual therapy. Often, the problem is someone else's responsibility, and the complainant is the victim. The most beneficial approach the therapist can take in this

relationship is to compliment the complainants on their insight into the situation and for being helpful to the therapist in better understanding the adolescent's behaviour. According to Berg (1994), "until the client has indicated that she is ready to take steps to solve the problems, any suggestions the worker makes should be limited to thinking, analyzing, or observing the presenting complaint" (p. 32). Since the complaining parent is already doing many of these activities, s/he will co-operate with the therapist. The task needs to agree with their perception of having an observer status.

Lastly, a customer relationship exists when a client clearly identifies the problem and is willing to work with the therapist on resolving the specific complaint. In these situations, the therapists can give behavioral tasks to the client "with a high degree of confidence that the customer will do the task and find it useful" (de Shazer, 1988, p. 89). "At times, it is difficult to make the decision about whether any particular person is at any particular time developing more of a 'complainant relationship' or more of a 'customer relationship' with the therapist" (de Shazer, 1988, p. 126).

In one single session, the relationship can "oscillate" between the two (de Shazer, 1988). de Shazer (1988) suggests that prior to assigning tasks to clients, the therapist must decide on the client-therapist relationship. Since this is not a clear 'yes' or 'no' choice based on a series of

questions, but is a "qualitative or evaluative description of a relationship", the answer is not always clear. According to de Shazer (1988):

> Sometimes the best a therapist can say is that the relationship fits 'more or less' well into one type rather than another. For instance, when the therapist cannot decide between complainant and customer, then even a well described exception (and/or hypothetical solution) might not be a suitable foundation for a behavioral task (de Shazer, 1988, p. 190).

It is best to be cautious and assign an observational task considering the client-therapist relationship to be falling into the complainant type. It is also important to consider how to respond to the way clients deal with tasks or suggestions. Have they been followed, modified, opposed, ignored, or forgotten? The therapist must be guided by such feedback to determine the next step. According to Cade and O'Hanlon (1993):

> ... if suggestions are followed as requested, then further such suggestions are indicated; if opposed, forgotten or ignored, then the therapist must carefully consider his or her position. Has he or she misjudged the extent to which a client or family is a customer, or has the therapist become more motivated than they are for a particular change? (Cade & O'Hanlon, 1993, p. 77).

During the initial interview, the therapist begins to look for exceptions to the problem behaviour. This allows the therapist to focus the conversation on what the client is already doing that can be characterized as successful and

useful, or, at least, heading in the general direction of dealing more effectively with the problem. "Exceptions take the form of useful patterns of behaviour, thoughts, beliefs, and feelings that have helped the client not to be pushed around by the presenting problem" (Selekman, 1993, p. 58). These exceptions can serve as building blocks for solution construction (Selekman, 1993). Questions such as "Is there a time when the complaint does not occur, or occurs less then at other times?"; "What is different about these times?"; "What are you doing differently?"; "How are you thinking differently?" can begin this process.

Durrant and Kowalski (1993) and Cade and O'Hanlon (1993) note that since this model's preference is to focus on solutions rather than problems, this may not immediately fit with the experience of some clients who come to therapy expecting to talk about problems. Not talking about the problem sometimes leads clients to feeling unheard. Therefore, Durrant and Kowalski (1993) and their colleagues aim to be attentive to exceptions to the problem or to other forms of competence from the beginning of therapy, they are also alert to their clients' lead and signs that they need to know that their situation has been understood and their experience validated.

The authors discuss different techniques the therapist can utilize to allow the client to talk about the problem, while beginning to identify exceptions and competence. These

techniques are: 'inducing doubt' into the way the clients see their situation; 'reframing' and; 'externalizing the problem'. Once the client seems to be able to appreciate a discussion of exceptions, the therapist leaves behind the problem-focused description and begins to focus more on solution-talk (Durrant & Kowalski, 1993). Sometimes clients are not yet able to describe how their life will be different when the problem is solved. In these situations, the therapist can still explore for exceptions but must do so by working from the complaint 'reality'. Questions such as "I am wondering are there days when you feel less scared about the future?" (clients' definition of the problem); "When was the last time you had a better day?"; "What was different about that day that made it better?"; "When did that happen?"; "Who was there with you?" promotes the expectation of change. "The therapist's positive stance is different from the clients' negative one and represents another opportunity to facilitate new perceptions and behaviours that can lead to solutions" (Lipchik & de Shazer, 1986, p. 94). Although the facts of a situation may not change, how they are perceived, or the context in which they are maintained are different, thereby offering the family new frames with positive and acceptable terms with which to live. Once an old frame is broken, the family system reorganizes itself and the change process is underway (de Shazer, 1982).

Within this framework, the therapist firmly suggests that

change is inevitable. "Therefore, the therapist's stance is not if change will occur, but rather when, or where, or what type of changing will occur" (de Shazer, 1984, p. 16). The therapist's choice of words helps to maintain a positive focus and support an optimistic view (Lipchik & de Shazer, 1986). Words such as 'will', 'when', 'where' and 'who' implies expectations of change, while words like 'might', 'would', 'could' and 'should' suggest a 'tentative' view.

de Shazer (1988) suggests other types of solution-oriented questions and techniques that will elicit existing exception patterns of behaviour from clients. These questions and techniques are:

1. The 'miracle question'. If the family is unable to identify any exceptions, the therapist asks the family the following question: "Suppose that one night there is a miracle and while you are sleeping, the problem that brought you to therapy is solved: How would you know? What would be different? What will you notice different the next morning that will tell you that there has been a miracle? What will your spouse notice?" (de Shazer, 1991, p. 113). This question is a tool which helps the client begin to think about solutions to his/her problem.
2. "Formula first session talk" was designed by de Shazer (1985) and his colleagues for clients who present with vague complaints. The clients are given the following task at the end of the first interview: "Between now and

the next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family or relationship) that you want to continue to have happen" (de Shazer, 1985, p. 137). After using this task, some clients have noticed things they wanted to have continue in their life. Clients have reported exceptions upon which solutions were built.

3. "Observation task". This task is very useful with over-involved and highly reactive parents with difficult adolescents. Parents may be instructed for one week's time to carefully observe their adolescent's behaviour for patterns of progress in order to better assist the therapist in trying to understand the behaviour. "The mere act of having the parents disengage and study their adolescent's behaviour can produce a difference or change in that behaviour" (Selekman, 1991, p. 41). By the same token, the parents' initial impression about their adolescent will also change" (Selekman, 1991).

4. "Do something different task". This solution focused task is also helpful with over-involved and highly reactive parents. The parents are given the following directive: "Between now and the next time we meet, I would like each of you to do something different, no matter how strange, weird, or off the wall what you do might seem" (de Shazer, 1985, p. 123). Parents have come up with some creative solutions and coping strategies

when given this task. It also eliminated that endless power struggles parents would engage in with their adolescent.

Given that the solution focused approaches focus on what the client wants rather than on what the therapist thinks the client should want, client goals are critical. Goals provide focus and ways to evaluate progress and outcome. According to de Shazer (1988):

> It might be more useful, in fact, to think about setting up ways to measure goal achievement rather than to set goals, because, with some frequency, the client is able to find a way to determine that therapy has been successful and he or she is more satisfied when something new or different happens that was not thought of as a possible measure of success (de Shazer, 1988, p. 93).

Lipchik and de Shazer (1986) go on to say that the goal is a small piece of the solution expressed in the most specific behavioral terms possible in order to serve as a useful guidepost toward solution" (p. 94). Sometimes clients are very vague about their goals. Therapists want the goal to be specific so that clients can more easily recognize what they will be doing or thinking (Walter & Peller, 1992). Lipchik and de Shazer (1986) report that "reducing the broader vague complaint to a normal specific one makes the solution appear simpler and more attainable" (p. 95).

Walter and Peller further state that "our concern with a

vaguely stated goal is that clients may not have developed signs of the goals' occurrence and, therefore, miss occasions when the goal is already happening" (Walter & Peller, 1992, pp. 210). Therefore, therapists want clients to go beyond the broad meaning and give the therapist more detail of their goals so they can recognize how the goal may be occurring now or how the goal will appear in the future (Walter & Peller, 1992).

The scaling questions can be used to negotiate well-formed treatment goals with clients, as well as exceptions or hypothetical solutions. In this way, the therapist and client can recognize and nurture small changes toward the goal rather than being stuck in problem thinking. The tasks and interventions that solution focused therapists use must promote solution behaviours and thinking in their clients. The purpose of each successive session is to assess change and to help maintain it so that a solution can be achieved.

In summary, solution focused therapy is a distinctive off-shoot of the brief and strategic therapy models. Steve de Shazer also acknowledges Milton Erickson's contribution to the solution focused model. "In fact, much of what solution-based therapists say and do might be considered an extension of Erickson's 'utilization' principle - the practice of making creative use of whatever resources the client brings to therapy" (Efran & Schenker, 1993, p. 71).

The core of the solution focused method is that

therapists do not spend any time searching for the cause of the client's problems or complaints. Instead, the model focuses on the exceptions, goals and resources that clients already possess to solve their problems. This focus serves to promote and emphasize client strengths and assumes that clients have the ability to make changes and resolve their problems. Throughout the sessions, the therapist needs to be developing a 'fit' with the client that s/he is interviewing. "Fit is a mutual process involving both the therapist and the people s/he is conversing with during which they come to trust each other's world view as valid, valuable and meaningful" (de Shazer, 1988, p. 90). By "staying close" and accepting the client's world view, the therapist helps resolve the complaint as simply as possible (de Shazer, 1988). It is the therapist's responsibility to maintain the therapeutic relationship and to promote the concept of 'fit'. The interventions that this model utilizes attempts in some way to help clients experience changing themselves. These interventions are built on the assumption that clients really do want to change or change is not only possible but inevitable.

Critics of the solution focused model have challenged its simplicity, briefness and the credibility of its scientific outcome (Wylie, 1990). Some articles on the solution focused model convey the impression that any problem can be treated successfully with a few solution focused sessions. What about

multi-problem families in which alcoholism and violence are the presenting problems? Can survivors of child sexual abuse achieve a sense of security and wellness in a month? Can addicts stop their habit after a few sessions? Sometimes the solution focused model can be effective with multi-problem families. However, critics of the model say that "believing chronic problems will almost always disappear in a few sessions, however skilful the technique, is itself a utopian fantasy, and there are enough brief therapy failures around to prove it" (Wylie, 1990, p. 31).

According to Wylie (1990), therapy focusing entirely on problem behaviour may be less efficient than long-term therapy, if it never addresses the function or purpose of the complaint. "Doing no more than interrupting the sequence of behaviours in marital conflict may solve the problem... but not if one spouse begins fights in order to maintain distance because of a lifelong fear of intimacy" (Wylie, 1990, p. 31). Critics complain that brief therapists often ignore the system that maintains a problem, "the hard-wired family network of co-dependency and collusion" (Wylie, 1990, p. 33). Furthermore, it is often not difficult to produce dramatic changes in clients' lives in a few weeks, but can the changes last longer than a few sessions? Efran and Veenendaal (1993) recently stated that solution focused therapists in their enthusiasm or impatience for 'solutions' or 'exceptions' to the problem could prevent the client from sharing their

complaints with the therapist. "Solution focused therapists can be accused of whitewashing anything negative... what assurance is there that clients of solution focused therapists haven't simply learned to keep their complaints to themselves in the presence of the therapists?" (cited in Nichols & Schwartz, 1995, p. 451).

Nylund and Consiglia (1994) state that many solution focused therapists may be unknowingly or knowingly practising 'solution forced' therapy. A solution forced therapist is someone who may minimize and even trivialize the client's experience of the problem because s/he is so determined to find exceptions to the problem and begin goal setting even though the exception questions do not make a difference to the client.

Durrant (1989) has stressed the importance of allowing clients to talk about their past and their problems so that they feel validated, heard and understood by the therapist. He made cautionary statements about the risk of '(mis)interpreting' the solution focused model:

> In contrast to some uses of de Shazer's 'solution focused' approach, which some therapists have taken to imply that the problem should not be discussed at all, my impression is that people come with a great concern about the problem and a failure to discuss the problem may amount to a disqualification of their experiences (Durrant, 1989, p. 8).

Such a disqualification of their experience is likely to invite them to argue even more strongly for the seriousness of

the problem. Put simply, clients need to 'feel heard' if they are to be able to consider alternate experiences (Durrant, 1989).

O'Hanlon's (1990) comments also emphasize the importance of inviting the client to teach the therapist what will be helpful and not let one's theories get in the way of the client's individual needs. In the same vein, White (1992) has stated that a therapist need not become 'problem-phobic'.

Durrant and Kowalski (1990) also cautioned therapists of the 'solution forced' practice of trying to attend and argue for exceptions that do not make a difference to the client. They stated that:

> It is important to convince clients that exceptions are significant. Attempting to convince often amounts to an irresistible invitation to argue even more strongly for the abuse (problem)-dominated view. Rather, we find it helpful to adopt a stance of curiosity and ask questions that invite clients to entertain ideas of personal agency (Durrant & Kowalski, 1990, p. 93).

A therapist may also practice the 'solution forced' approach when they have little understanding and background knowledge of the theories underlying the brief therapy model (Ericksonian, structural systemic). Like any other model, it evolved from years of thought, research and experience and cannot be picked up on the 'run'.

Lastly, Hubble and O'Hanlon (1992) forewarn that even with a thorough grounding in solution focused theory, we can still fall victim to 'theory countertransference' where we so

envelop ourselves in our own theories of change, that we fail to appreciate and utilize what ideas and resources the client brings in that may facilitate change. To ignore these possibilities increases the likelihood of a practice in solution-forced therapy (cited in Nylund & Corsiglia, 1994, pp. 10 - 11).

Currently, solution focused therapists themselves have started expressing doubts about the models 'injunction' to continually remain 'upbeat' (Nichols & Schwartz, 1995). Storm (1991) states:

> I have found that being relentlessly solution focused is a mismatch for some clients. These individuals insist on talking about the problem in detail and, if ignored, fire the therapist. I thought I was misapplying the approach but now I believe I... overemphasized change (Storm, 1991, pp. 116 - 117).

Efran and Veenendaal (1993) state similar concerns:

> Our experiences do not permit us to completely accept the enthusiastic positiveness of the solution focused model... When we attempt to use these models and stances exclusively, we build up a sense of wrongness and futility, as if we were somehow pulling the wool over the eyes of clients and ourselves (Efran & Veenendaal, 1993, p. 17).

Maybe it is not the solution focused techniques themselves that have caused this kind of disappointment, "but the rigid, formulaic ways they have come to be applied" (Nichols & Schwartz, 1995, p. 451).

Outcome Studies

In 1988, the Brief Family Therapy Centre conducted what is probably the most ambitious, comprehensive and long-term follow-up study ever done of therapy designed to be brief (Skyes, 1990). Family therapist David Kiser (1988), has found that about seventy-five percent of their cases had at least some relief from their presenting complaint (cited in Nichols & Schwartz, 1995). In another study done by Watzlawick, Weakland and Fisch (1974), it was found that eighty-five percent of the clients reported full or partial success (cited in Nichols & Schwartz, 1995). This kind of research does not appear to be very scientific, however, it does indicate that solution focused therapists may have a significant number of "satisfied customers" (Nichols & Schwartz, 1995).

In conclusion, not withstanding the empirical scrutiny subjected by some other theoretical methods and their respective research studies, the solution focused model does have a basis of efficacy. While this is not founded on empirical base, the Brief Family Therapy Centre concurs with Fisher's (1984) findings which indicate that things do continue to get better rather than deteriorate after brief therapy (de Shazer et al., 1986).

An Integrated Structural/Solution Focused Model of Family Therapy

Frequently, there has been confusion as to how the structural and strategic approaches can compliment one another and how they differ. Many therapists are often unsure as to whether they might be able to use both approaches during treatment. "They sense the similarities and wonder whether 'purity' must be maintained or whether the two can be applied interchangeably or in combination, perhaps according to a certain rule" (Stanton, 1981, p. 427). Certainly there are differences between the two approaches, especially at the theoretical level. No model of family therapy completely "encompasses both modes adequately" (Stanton, 1981). According to Stanton (1981)... "the clinician cannot always wait for the emergence of theoretical harmony in order to do his job and must proceed as best he can with the tools available" (p. 427).

Before discussing whether or not the two therapeutic approaches should be integrated, it seems fitting to note some of the common assumptions that characterize the structural and strategic (in this case, solution focused) models. Fish and Piercy (1987) conclude that both approaches (a) are present focused; (b) are change, rather than insight oriented; (c) view problems in their relationship context; (d) give directives; (e) assign tasks; (f) are interactional or

contextually oriented and; (g) are goal directed and concerned with the outcome of therapy. Todd and Selekman (1991) identified other common assumptions that characterize to some degree these two approaches. These are: (a) build on strengths; (b) pragmatic - emphasis on what works; (c) therapist plays active role; (d) solution is unique to each family; and (e) therapy is relatively short-term (Todd & Selekman, 1991). It is these sets of assumptions that makes these models relatively compatible on an operational level.

Fish and Piercy (1987) further state that in learning an integrated approach, the therapist must first understand the theoretical distinctions between the two approaches. This can be accomplished "by teaching or supervising beginning clinicians in either structural or strategic therapy alone, but not both in combination" (Fish & Piercy, 1987, p. 124). According to Lebow (1984), several authors have begun to pay attention to the similarities among the different family therapy approaches and to the development of integrative methods of treatment that incorporate these diverse approaches. This has caused a debate among family therapy authors regarding the value of integration (in this case, Lebow refers to the structural and Haley's strategic approaches). Other treatment approaches are difficult to categorize, because they do not fit neatly into the "behavioral, structural/strategic or psychodynamic metacategories" (p. 127). According to Lebow (1984),

integrative approaches have several strengths. These are:

> Integrative approaches draw from a broad theoretical base; as such, they can explain human experience in a more sophisticated manner than can simpler theories and better account for the range of human behaviour. Integrative approaches also allow greater flexibility in the treatment of any given individual or family, and thus offer the opportunity for increased efficacy and acceptability of the care. It is also applicable to a broader client population than more narrowly focused approaches. It allows for the selection of an intervention strategy that best fits with the client's needs. Better able to match the treatment they offer to their own personal conception of problem development and change. Therapists can also combine the major strengths of specific approaches. They can also bring greater objectivity to the selection of strategies for change. Can also be readily adopted to include new techniques which have been shown to be useful. Beginning clinicians can draw from a wide variety of creative and innovative approaches which have emerged in family therapy over the last three decades, rather than a limited range of alternatives (Lebow, 1984, pp. 128 - 132).

Furthermore, de Shazer (1985) talks about the "poly-ocular view" which suggests that various approaches have been utilized in therapy. This perspective "can produce a bonus, an idea of a higher logical type" (de Shazer, 1985, p. 171). He goes on to say that each approach to therapy can offer a valid interpretation of the same situation. Since both structural and strategic therapists do useful therapy, "their models are sort of like two eyes looking at the clinical situation" (de Shazer, 1984). By looking at a situation with both eyes, therapists have a better chance of understanding what is going on. "It will give us some depth of understanding, and perhaps, a bonus of better understanding

the clinical job which is promoting the change the client hired us to do" (de Shazer, 1984, p. 36). According to de Shazer (1984), "multiple description, while sometimes confusing, can enrich our vision and give us a better understanding of the whole process of therapeutic intervention and problem solution" (p. 34).

It appears clear that if a therapist can maintain a clear conceptual difference between models, the use of more than one model in our work is possible. The two approaches complement each other to enable the therapist to understand the problem in such a way as to allow for effective intervention with families. However, to maintain conceptual distinction or clarity between the two models, Stanton (1981) proposes three general rules for combining the two approaches in practice. These rules are:

1. Initially deal with families through a structural approach;
2. If structural techniques appear unlikely to succeed, then switch to a strategic approach;
3. Following success with the strategic methods, revert once again to a structural approach.

In order to maintain conceptual precision between the two models, initially I utilized the structural approach to determine family structure and how it was functioning. A solution focused approach was utilized to assist families to

construct workable solutions in their lives and to explore exceptions. The emphasis was on utilizing the clients' strengths to help create a satisfactory life. Often, I would shift from one model to another in order to better meet the needs of different families. Liddle (1984) has noted that "many structural/strategic therapists also assume a clear, uni-directional pathway, first structural then strategic, again using the latter only after the former fails" (p. 70).

The rules outlined by Stanton (1991) helped me with a method for integrating the strongest and most appropriate elements of each therapeutic model. In addition, these rules facilitated my learning by helping me to maintain conceptual clarity during my placement.

Lebow (1997) examined what made integration successful. He concluded that there was no single answer to this question. However, he did comment that there are several common threads that characterize the best integrative therapies. These are:

> Each model is quite specific in spelling out what is included and how, moving well beyond the vague notion that more is better. Each builds from core assumptions that are clearly stated, and each transmutes the constituent methods rather than simply adding ingredients, digging down to a level that pushes our understanding of how the included elements relate to and affect one another (Lebow, 1997, p. 13).

Even though the best integrative therapies are strong in concepts and interventions, each also highlights some simple focus around which treatment is developed (Lebow, 1997).

Lebow (1997) goes on to say that "each suggests specific methods for conceptualizing and intervening, yet each also underscores the importance of core, generic factors in effective psychotherapy, such as the creation of hope and the building of the therapeutic alliance" (p. 13). He concludes that the best integrative therapies promote treatment strategies that have high probabilities of success in treating the difficulties in focus, but also allow the clinician considerable flexibility (Lebow, 1997, p. 13). It should also be simple to teach and be able to offer clear guidelines for practice, while allowing "improvisation" and spontaneity, especially in the hands of more experienced therapists (Lebow, 1997).

Overall Effectiveness of Family Therapy with Adolescents and Their Families

Reviews of family therapy outcome research indicate that family therapy is the "most powerful therapeutic intervention for working with adolescents" and it represents the "treatment of choice" in these situations (Fishman, 1988). Alan Gurman and David Kniskern (1981) have reported significant improvement in individual and family functioning when a family systems approach is applied to the treatment of delinquency, aggression and behaviourial difficulties.

Roy and Frankel (1995) have written a book that examines

the family therapy outcome literature regarding the efficacy of family therapy with children, adolescents and adults. They also review the efficacy of family therapy for certain well-defined clinical problems, i.e., anorexia nervosa, drug addiction, and other problems. The studies that Roy and Frankel (1995) discuss on delinquency are weak in terms of "methodological rigour" and, therefore, provide limited support for family therapy as "treatment of choice" with adolescents involved with the law. Michaels and Green (1979) also evaluated the effects of family therapy with delinquent youths and their families. They concluded that "... children in the family therapy group not only remained at home at a greater rate, but also experienced fewer placement episodes than those in the comparison group" (cited in Roy and Frankel, 1995, p. 40). Michaels' and Green's study (1979) lacks rigorous methodology, and therefore, it becomes difficult to rule out alternative hypotheses.

Roy and Frankel (1995) cite other studies that investigate the effectiveness of family therapy with families in which an adolescent had a criminal record. They concluded that even though these studies included minor "methodological improvements", their findings did not support the effectiveness of family therapy with families of offenders (Roy & Frankel, 1995). According to Roy and Frankel (1995):

> Taken as a group, these investigations shed little light on the question of the effectiveness of family therapy

> with families of status offender adolescents. The mixed results are as easily attributable to weaknesses in methodology as to the intervention under study. While all of the studies employed a comparison group, none was constructed through random assignment or careful matching... Specific treatment approaches, service characteristics, and client characteristics (especially family functioning) are generally inadequately reported (Roy & Frankel, 1995, pp. 43 - 44).

A more elaborate study was conducted by Alexander and Parsons (1973) to investigate the effectiveness of functional family therapy in altering the inefficient family processes in the families of status offenders. Results showed that functional family therapy is effective in working with status offenders and their families. However, Roy and Frankel (1995) note several limitations of this model. They state that offenders are assumed to be a homogenous population and there are no attempts to differentiate among families by offenses. As a result, important information about predictors of effectiveness may be missing (Roy & Frankel, 1995).

Roy and Frankel (1995) reviewed eight other studies that explored the effectiveness of family therapy with families of adolescents who had committed other forms of juvenile delinquency. The studies described are diverse in that they deal with first time and chronic offenders who were treated in both institutional and community context (Roy & Frankel, 1995, p. 48). Results of these outcome studies showed that treatment based on combined systemic and behavioral techniques and assumptions appeared to be more effective than the

services usually provided for delinquent youth. However, "the evidence is most pronounced in relation to recidivism and for less convincing in the areas of improved family functioning" (Roy & Frankel, 1995, p. 55).

These outcome studies also lacked in "rigorous methodology", including inadequate instrumentation, problems of operational definition of family treatments and inadequate sample selection. "Overall, there is a cause for cautious optimism about the effectiveness of family therapy for this population" (Roy & Frankel, 1995, p. 58). The authors conclude that "rigorous methodology" that must be applied if family therapy is to go beyond the "stage of being a mere act of faith" (Roy & Frankel, 1995).

Roy and Frankel (1995) also reviewed a number of studies related to adolescent drug abuse and the effectiveness of family therapy with this population. It was noted that these studies paid very little attention to describing their samples. Most of the research included samples that were too heterogenous, in terms of types of drugs used, the severity of the abuse, and the existence of other difficulties (Roy & Frankel, 1995). At this time, it seems that family therapy may be an effective means of reducing drug use among adolescents (Roy & Frankel, 1995). Furthermore, the outcome findings indicate that changes in family functioning may occur at the same time as changes in drug use. However, the question remains open, whether family therapy is more

effective than other treatment approaches with drug abusing adolescents (Roy & Frankel, 1995). Roy and Frankel (1995) concluded that:

> Despite all the major methodological shortcomings including lack of control groups, small and ill-defined samples, lack of attention to therapist variables, inadequate instrumentation, poorly-defined outcome measures, confusion over dependent and independent variables, multitude of outcome measures etc....the consensus among reviewers is that family therapy with some qualifications, works (Roy & Frankel, 1995, pp. 16 - 17).

CHAPTER THREE

PRACTICUM METHODS, PROCEDURES AND EVALUATION INSTRUMENTS

Evaluation Instruments

Several instruments were used to evaluate different parts of the practicum. The two standardized instruments that were used were the Family Assessment Measure III (FAM111) (Skinner, Steinhauer, & Santa-Barbara, 1983) and the problem checklist originally designed for the Morrison Youth Centre in Oregon. Both instruments were administered to client families at the beginning and again at the end of therapy or near the end of the initial treatment contract.

In addition, a self-anchored scale was administered to two or three client families periodically over the entire course of intervention. This measure gave continuous feedback to the client and the therapist regarding changes in the family system.

The FAM111 (Appendix A) was used as a primary measure with client families. The FAM111 is a self-report measure which is based upon Canadian norms for both clinical and non-clinical populations (Trute, Campbell & Hussey, 1988). It is also based upon the process model of family functioning which identifies a variety of basic, developmental and crisis tasks for the family (Steinhauer, Santa-Barbara & Skinner, 1984).

Basic tasks are generally affiliated with providing food,

shelter and other essentials on a daily basis. Developmental tasks are associated with the individual and the family life cycles and crisis tasks are those which happen when family members must mobilize new skills and resources in order to deal with specific stressors (Steinhauer, Santa-Barbara & Skinner, 1984, p. 79).

At the functional level, these tasks include "allowing for the continued development of all family members, providing reasonable security, ensuring sufficient cohesion to maintain the family unit, and functioning effectively as part of society" (Skinner, et. al., 1983, p. 93). Successful accomplishment of these tasks occurs when family members agree and accept responsibility for, and complete, the various tasks which are assigned to them. If this happens there will likely be less conflict and more satisfaction with role performance for all family members because each is aware of what is expected of them and each knows what they can expect from others in the family (Steinhauer, et al., 1984, p. 80).

Clear and direct communication is central to role performance. The ability to express feelings and emotions appropriately and effectively in a family system (i.e., Affective Expression) can prevent or promote communication and successful role integration. The degree and quality of interest family members have for one another (i.e., Affective Involvement) also helps to "determine whether relationships are nurturant and supportive, or destructive and self-serving"

(Steinhauer, et al., 1984, p. 81). In healthy families, family members are able to maintain a sense of autonomy and emotional security in order to balance the needs of the individual family members with the needs of the family itself. This also contributes to successful task accomplishment. Control is a critical component within the family process since families are required to influence the behaviours of family members in order to maintain the family in its current state or to support the family as it changes in response to specific tasks, demands or crises. If family members behave in a flexible, responsible and predictable way, they can influence and guide each other's behaviour and promote task accomplishment.

The family's cultural background (i.e., values and norms) influences how it assigns, defines and achieves its tasks and the degree of congruence between its behaviours and the broader cultural context (Skinner, et al., 1983).

FAM111 consists of the General Scale, the Dyadic Relationship Scale and the Self-Rating Scale. Only the 50 item General Scale of FAM111 were used in this practicum. The measure was utilized to evaluate changes in family functioning over time.

FAM111 has internal consistency, reliability, and moderately high correlations with social desirability and defensiveness. The alpha reliability coefficient on the overall rating of the General Scale is .93 for adults and .94

for children. The reliability of the various subscales ranges from .65 on the defensiveness to .87 on social desirability for adults and from .60 on task accomplishment to .87 on social desirability for children (Skinner, et al., 1983). The FAM111 scale "has excellent psychometric properties which include high internal consistency, indicating the presence of a general factor of family health-pathology... " (Trute, Campbell & Hussey, 1988, p. 18). Also, the FAM111 scale differentiates well between normal and pathological family systems (Skinner et al., 1983).

The Problem Checklist (Appendix B) provided a self-report from all family members about their levels of satisfaction with each other. This instrument is useful as it encourages family members to identify concerns over a wide range of family dimensions and allows them to raise specific concerns which family members may be reluctant to identify or may not acknowledge verbally (Trute, 1988, p. 106). The Problem Checklist was considered weak in its generalizability and empirical strength (Trute, 1985).

The Self-Anchored Rating Scales (Appendix C, D, E) were designed by the student to measure specific problems that other standardized measures may not be able to pick up. These scales were only used with specific clients to measure the intensity of problems before and during intervention. "Self-Anchored Scales can be used to evaluate internal thoughts and feelings, or the intensity of those thoughts or feelings, that

other measures cannot tap" (Bloom & Fischer, 1982, p. 169). Therefore, thoughts and feelings such as fears, anger, depression, self-concept, and particular situation-related feelings can be measured (Bloom & Fischer, 1982). The Self-Anchored Scale measures thoughts or feelings that only the client can report on, therefore, it is high in validity. On the other hand, the scale has some inherent weaknesses, especially in reliability and reactivity. "Given the subjective nature of these ratings there is a high potential for a client to distort or change his or her ratings and/or behaviour" (Bloom & Fischer, 1982, p. 169).

Overall, the Self-Anchored Rating Scale provides a client's perspective on the impact of intervention during therapy and it supplements the results of the other measures used in this practicum. In addition, this scale is future-oriented and solution focused. This measure is similar to the scaling questions used by solution-oriented therapists to measure the family's concern before and during treatment, to determine clients' investment in change, to determine clients' confidence in taking steps to solve problems and to assess any perceptions of solutions. For example, the therapist may ask the client: "On a scale of 1 to 10, with 1 being the worst things have been and 10 being the miracle, where are you right now?". "What will you be doing differently when you move one more step up the scale?". When clients indicate that they are at 4 on the scale of 1 to 10, and the next week they are at 5,

therapist and client have a measure of progress. The therapist then can ask the client the following questions: "How did you manage to move up the scale?"; "What lets you know that you are at 5 instead of 4?"; "What are you doing that lets you know that you are at 5?". In this way, the therapist re-inforces client change and assists the client to identify the specific behaviours that are part of the change process.

The last measure used to assess my professional and personal growth was an altered version of the Client Feedback Form (Appendix F). This was achieved through the administration of the Client Feedback Form by a neutral employee of the agency three to four weeks after the completion of therapy. This form asked clients' opinions about what the therapist did that worked, what the therapist did that did not help, and if they had any other comments or suggestions. The student administered the Client Feedback Form to a few families. This allowed the student to ask focused questions of family members about the therapist's 'use of self', the effects of treatment and the usefulness of the models, i.e., did they feel that they were understood by the therapist?; what particular relationship skills did they find useful?; did they find asking questions about their past successes helpful?; did they find the exception questions trivializing and repetitious?; did the 'miracle question' help them with the identification of treatment goals?; did they

feel it was appropriately used by the therapist?; were solutions clearly defined?; did the assigned tasks fit with the family's world view?; were they helpful?. Focused questions of this kind increased my learning and facilitated my growth as a family therapist.

Setting

The setting was New Directions for Children, Youth and Families (formerly Children's Home of Winnipeg) in the Family Therapy department. New Directions is a private, not-for-profit human service agency which provides a unique combination of human services which include clinical services, residential services for youths, a sexual assault program which provides services to victims and their families, training and employment for youths, services for unmarried mothers, a parent support program and services for multi-handicapped. The staff is multi-disciplinary, consisting of social workers, psychologists, teachers/instructors and a consulting psychiatrist. The Family Therapy Department at New Directions has a dual mission: 1. To provide treatment to families experiencing difficulties with their children or adolescents; and 2. To provide training and consultation to other professionals who work with youth and families.

Clients

The client population of this practicum was composed of adolescents and their families who were referred by other social service agencies (i.e., mental health, child welfare, hospitals, schools) or by the families themselves for therapy to resolve outstanding problems. Six families were seen during the practicum placement. A common feature of two of the families was that they were families with adolescents for which familial issues involved the adolescent family member (identified patient). The other four families had young children. In further discussion of the practicum process, three families will be highlighted as case studies. Two of the families involved adolescents and one family had young children.

During my practicum placement, the reality of intake was that more families with young children were referred to family therapy than families with adolescents. Also, more families with young children were committed to following through with family therapy than families with adolescents. In families with adolescents, the identified problems included: parent-adolescent conflict, adolescent behaviour problems involving delinquency, running away, physical aggression, and deteriorating or poor school performance. In families with young children, the identified problems included: parent-child conflict, parenting style, communication, and coping

with day-to-day stresses without further hurting his/her children.

In order to provide for a broad range of clinical experiences, this practicum did not set any limitations based on family form. Treatment was provided to intact, single parent, blended and foster families. Initially, families were pre-selected by Mr. Bernie Klippenstein according to the following criteria: (a) families were more intact structurally, and as a result, more manageable for a beginning student; (b) only one person was identified as a problem at intake; (c) no multiple-helper systems were involved with the family or only a few professional systems were involved; (d) no obvious mental health issues were in the family system; and (e) the family members were positively connected. Once the initial selection was made by Mr. Klippenstein, I then selected the cases I felt were interesting and challenging from that group.

Personnel

Clinical supervision was provided by Mr. Bernie Klippenstein, M.S.W. and Dr. Harvy Frankel, who is my faculty advisor. Dr. Diane Hiebert-Murphy also provided consultation on an informal basis. The members of my committee were: Dr. Harvy Frankel, Bernie Klippenstein, M.S.W., and Dr. Diane Hiebert-Murphy.

Duration

The practicum started in September of 1996 and ended in July 1997. My placement was part-time. This meant that I spent one day per week in the Family Therapy department for a period of ten months. My committee members met with me halfway through my practicum to evaluate and provide feedback on my practicum. This session also allowed me the opportunity to share my experiences, growth and struggles with my supervisors.

Procedure

A model of systemic family therapy which integrates a structural assessment with a solution focused interventive strategy was used. The structural model was primarily used for assessments and tracking of family change. The solution focus organized interviews and the intervention used. Interviews occurred in the Family Therapy Department and were videotaped or observed at all times by my clinical supervisor. Live supervision was provided through a one-way mirror and with the aid of a telephone or 'bug' in the ear. Further consultation was available during session breaks and at the end of sessions.

Recording

Recording followed the procedures and format set out by the agency. An initial assessment was completed on all referrals. The initial assessment included relevant background information, identified problems, assessment of family functioning and a proposed treatment plan. The student was expected to document all interviews. This format required reports on the focus of each session and the intervention used. I also maintained a journal that documented my learning goals, personal growth, development and struggles. All therapy sessions were videotaped to facilitate self-review and consultation with my supervisors.

Evaluation of Therapist's Skills and "Use of Self"

One of my main goals in this practicum was to develop and acquire skills as a therapist. Emphasis was placed upon two views of my skill development: 1) "perceptual/conceptual skills", as shown by my ability to identify and explore dysfunctional patterns in the family and determine appropriate treatment goals; and 2) "executive skills", as demonstrated by my ability to use my own emotional and behavioral reactions constructively to help attain treatment goals (Tomm & Wright, 1979). The structural approach identifies the therapist as central in the therapeutic relationship, therefore, training

emphasizes the strategic "use of self" within the therapeutic relationship. According to Aponte and Winter (1987), "Minuchin called for the therapist's 'widest possible use of self' as the therapist 'uses himself to transform' the system, explaining that 'a therapist cannot observe and probe from without... he must be part of a system of interdependent people" (p. 271). The structural model also emphasizes "technical skills" and technical competence that the therapist uses to influence change (Aponte & Winter, 1987).

The solution focused model also considers "technical skills" important but views "personal skills", such as a sense of humour, warmth, using the client's language and beliefs, and focusing on strengths and resources as important for effective therapy. From the existing literature , it is not clear what skills should be emphasized in a training program to become an effective therapist.

Kniskern and Gurman (1979) state that the therapist's skills i.e., directiveness, clarity, self-confidence, information gathering and stimulating interaction, and relationship skills (affect-behaviour integration, humour, warmth) are factors which influence the positive treatment outcomes of marital-family therapy regardless of the theoretical orientation of the therapist (p. 84). Therefore, "to the degree these factors are teachable, learnable and focused upon in training programs, their identification provides indirect support for the potential effectiveness of

family therapy training programs" (Kniskern & Gurman, 1983, p. 83).

Recently, Figley and Nelson (1989) recognized the need to generate a list of basic family therapy skills that educators believed to be critical to beginning family therapists of all schools. Through their research they found that the panel of experts nominated and rated personal attributes or traits as being the most important generic skill to have as a beginning therapist. Some of these were: express caring, recognize client's world views, be accepting, sense of humour, respectful of differences, be sensitive, establish rapport, ability to control own anxiety and capacity to take responsibility for own mistakes (Figley & Nelson, 1989, pp. 360 - 361). Based on this data, Figley and Nelson (1989) concluded that "... educators/trainers seem to believe... that the person of the therapist is as important, if not more so, than the skill of the therapist" (p. 362).

In another study, Figley and Nelson (1990) asked the same panel of experts to nominate and rate a list of skills that they regarded important to a trainee in structural family therapy. One hundred skills were nominated and rated by the experts and as a way of clarifying the findings, the researchers organized the traditional groups into conceptual, perceptual and behavioral skills.

In this study, a number of personal traits were nominated and rated, but most of the items identified were behavioral

skills that could be operationalized and measured. Many of the items related to the general concepts of structural family therapy such as boundaries, coalitions, subsystems, reframes, and enactments (Figley & Nelson, 1989, pp. 237 - 238). Other items were related to activities in therapy (e.g., issuing directives, challenging family members, using circular questions) that are consistent with the literature on structural family therapy (Aponte & Van Deusen, 1981; Fishman, 1988; Minuchin, 1974; Minuchin & Fishman, 1981).

Figley and Nelson (1990) believe "beginning structural therapists should know the meanings of structural ideas and be able to use them when thinking about families (conceptual skills)" (p. 238). More complex executive skills (e.g., "escalating intensity" or "uncovering covert conflict") are considered less important to a beginning therapist's growth and development than simpler tasks (e.g., "assess how structure is dysfunctional" or "read a family structurally").

According to Kniskern and Gurman (1979) "the meaning which one attaches to the term family therapy will directly affect the way in which one trains family therapists and evaluates that training" (p. 85). If family therapy is seen as a technique, then a training program will focus mainly on the acquisition of technical skills and the acquisition of specific technical skills will be seen as the most appropriate measure of the success of the training program (Kniskern & Gurman, 1979, p. 85).

On the other hand, if family therapy is seen as a blend of technical and personal skills, then the relationship that the student is able to form with the family becomes just as significant a training goal as does technical ability. Therefore, in order to challenge myself, I had to adhere to the perceptual, conceptual and executive tenants of the therapeutic model I was using with a family at any given time. The focus on perceptual and conceptual skills as a basis for practice is appropriate for beginning and experienced therapists, since it emphasizes the theoretical dimensions of practice which should inform the executive manoeuvres of the therapist. In this way, I was able to challenge myself to begin to develop my executive skills within the boundaries of the model.

CHAPTER FOUR

CASE REVIEWS

Introduction

During my practicum placement, I saw a total of six families. Four of these families were single parent families, one was a blended common-law family and one was a traditional nuclear family. Two of the single parent families that I saw over the course of this practicum were recently divorced. The other two single parent families had been raising their children alone for many years.

All of the families were referred by the mother except for two, which were referred by play therapists. The families came from a range of socio-economic backgrounds. The number of sessions per family ranged from a low of two to a high of thirteen. All of the sessions took place at New Directions for Children, Youth and Families.

The families presented the following problems as initially described by the referral source: 1) an adolescent who was unhappy, withdrawn, and skipping school; 2) an adolescent who was moody, very angry, and difficult to control and conflict over household chores; 3) behaviour problems, worse since the child began to spend time with his father; 4) a mother concerned over separation and its effect on her children; 5) an adolescent who was non-compliant and

aggressive towards siblings and parent.

Of the six families involved in this practicum, three cases were chosen to illustrate the therapeutic process or treatment. The therapeutic process is broken down into the following format:

1. Source and reason for referral;
2. Initial interview summary;
3. Structural assessment;
4. Treatment goals;
5. Strategies to implement the goals;
6. Course of therapy;
7. Evaluation of therapeutic outcome (FAM111 and Problem Checklist)

After each case example, I will describe what I learned from my experience with this family. This includes an analysis of what I could have done differently and what I learned as a therapist in the training of family therapy methods.

Details of the three other families are included in Appendices Q through S. Each of these appendices includes a description of the family structure, an explanation of the presenting problems and the outcome results of FAM111 and the problem checklist. One family did not complete the post measures because the family did not continue with therapy

after the sixth session. The names of family members and other identifying information have been changed to protect confidentiality.

Case Example 1: Family 'A'

The family included Ruth, a 47 year old single mother who had been divorced for twenty-four years. Ruth had three children, a 15 year old daughter, Patti, and two married daughters.

Source and Reason for Referral:

Ruth referred her daughter, Patti, because she was concerned and frustrated about Patti's non-compliant behaviour at home and not attending school on a regular basis. Ruth wanted Patti to show more respect and to be more responsible. She stated that she was unable to discipline Patti effectively and that Patti frequently swore and yelled at her. Patti also stayed out at night past her curfew time. Ruth said that she had talked to Patti about her unacceptable behaviours a number of times, but she continued to ignore her. Ruth was also concerned about not treating Patti well, and as a result, she worried that she was going to lose her.

Initial Interview Summary:

Ruth came for the initial interview. Patti did not attend. Ruth was on social assistance and was actively seeking employment after she had completed a course on job search with Canada Employment. She was hoping to be able to obtain a job as a store clerk on a part-time basis. Ruth presented as a very caring, soft-spoken and nurturing mother who was very concerned about Patti. Most of her day was spent worrying about Patti, or saving her from problems with her school or friends. She devoted much of her time and energy to Patti's care and support. She took pride in her ability to raise Patti on her own but she acknowledged that she had been very protective of Patti. Ruth also admitted that she had sacrificed many of her interests in order to provide for Patti and she wondered whether Patti appreciated all that she had done for her. Ruth had not seen Patti's father since her birth. He lives in Edmonton with his new wife and children and does not appear to be interested in forming a relationship with Patti.

Structural Assessment:

The parental and the sibling sub-system was fused and over-involved. The personal boundaries were vague and unclear. As Patti was beginning to individuate and demand

more autonomy, Ruth became more controlling and anxious, which created problems between Patti and Ruth. Ruth worried too much about Patti's safety and, as a result, permitted little opportunity for Patti to learn from experience.

Ruth appeared to be unable to determine and to meet Patti's actual needs as Patti began to individuate during adolescence. This may have been due to her own need to gain emotional support and comfort from her. The initial FAM completed by Ruth appeared to support the notion that Ruth drew emotional support from Patti and that she felt abandoned by her as she attempted to individuate. Her initial scores on affective involvement and role performance subscales were elevated above the normal range (see Appendix G). In addition, her parenting style took extreme forms. Consequently, when Ruth set limits and rules for Patti and Patti disregarded them, Ruth was unable to follow through with her consequences because she was afraid of 'losing' Patti. Other times, when Ruth became very frustrated and anxious, she would threaten to kick Patti out of the house and have Child and Family Services gain control of her. The result was a daughter who continued to behave immaturely and out of control and a mother who felt defeated and ineffective as a parent.

The scores on the pre-test FAM111 (Appendix G) showed that Ruth identified role performance, affective involvement, communication and control as problems, supporting the hypothesis that the mother was experiencing conflict and

tension in adapting to the adolescent phase of the family life cycle. The mother's elevated score on the affective involvement subscale indicates that she was overly-involved (enmeshed) with Patti. The elevated score on the control and communication subscales were consistent with Ruth's verbal reports about the conflict with her daughter, Patti, and her feeling of inadequacy about her role as a parent with a challenging adolescent. Patti did not complete the measures as she refused to participate in therapy.

On the initial problem checklist (Appendix H), Ruth was dissatisfied in 8 of the 22 areas listed. She rated herself 'in-between' in 8 areas, and 'satisfied' and 'very satisfied' in the remaining 4 areas.

Treatment Goals:

1. Help Ruth take a leadership role in the family.
2. Enable Ruth to discuss her rules and expectations of Patti in a clear and direct manner.
3. Establish clear boundaries between the parental and adolescent subsystem.

Strategies to Implement Goals:

1. Teach Ruth how to discuss issues with Patti and how to take a clear and firm position as a parent.

2. Help Ruth to articulate her expectations of Patti in therapy and then teach her through role plays how to convey these to Patti.
3. Help Ruth to engage with Patti in a different, less intrusive manner.

Course of Therapy:

Sessions Two to Four:

I saw this family for thirteen sessions. I met with Ruth alone for eleven sessions following the initial interview.

Initially, Patti refused to attend any sessions. However, Patti did attend two sessions with Ruth. At the end of the first session, I asked Ruth to consider the ways in which she wanted Patti to behave differently, and to write these expectations down and bring it to the following session. When Ruth arrived for the second session, she stated that she wanted Patti to show more respect and responsibility. Ruth wanted Patti to go to school, get an education and not "waste her life", to not socialize with a group of friends that had a "bad influence" on her and to not swear and yell at her when she had requested Patti to help out around the house. Since these concerns had existed for a while, I asked Ruth what she had done to attempt to change Patti's behaviours. Ruth stated that she had "threatened to throw her out" and often argued

with Patti. When this occurred, Patti responded with angry accusations and then withdrew, leaving Ruth feeling rejected and guilty. Other times, Ruth withdrew from arguments or attempted to "buy Patti off", even though she could not afford it. Ruth was complimented on her concern for and commitment to her daughter. I told Ruth that I was very impressed with her persistence, that she had not given up even when she was not treated with respect by Patti. This was done to support and facilitate the change process because giving compliments to clients offers a context of "good" (Walter & Peller, 1992). Clients become more open and relaxed and, as a result, they are more likely to suggest new ideas and look at their situation in a new of different way.

My assessment was that Ruth had difficulties with setting flexible limits with her growing daughter and enforcing them. Also, communication was an issue. Specifically, individuals did not feel heard or understood because their primary communication was in the form of yelling at each other or nagging and long explanations of consequences. Furthermore, Ruth communicated with Patti in a confusing manner. Ruth wanted Patti to be more responsible but offered few opportunities for her to make her own choices.

In the following session, I suggested to Ruth that she needed to "step back" and allow Patti to assume more responsibility and independence and to accept the consequences of her actions. Ruth should only intervene when it was

absolutely necessary. I made this direct suggestion to Ruth because I wanted her to begin to withdraw from rescuing and taking responsibility for Patti's problems. I was encouraging the development of clearer boundaries between Ruth and Patti. This intervention was also aiming to help Ruth develop a greater sense of competence in her maternal functioning and helping Ruth and Patti become connected in a more respectful way. This promoted differentiation, autonomy and competence in Ruth and Patti. I was asking Ruth to go beyond her accustomed patterns of behaviour where she actually supported and encouraged Patti's autonomy and competence. The existing patterns within the family had served to push Patti further away from Ruth and had risked her chances of exercising effective parental control in those areas where she needed and was entitled to act.

This strategy is similar to the solution focused strategy of reframing. Reframing is a process that guides therapy towards change by presenting different perceptions of reality for family members (de Shazer, 1988, 1991). As change must occur beyond the therapeutic environment, it is crucial that families not only show insight but change behaviours that occur simultaneously with their interpretation of reality.

The process of reframing contains seeing problems in a new way through exceptions, goals and solutions, but also in formulating new rules to define situations (de Shazer, 1982).

In Ruth's situation, the negative consequences of her

parenting style was discussed and explored through reframing and how the impact of doing more of the same prevented her from forming solutions or exceptions to the complaint. I encouraged Ruth to do something different. I gave Ruth the following directive: "Between now and the next time we meet, I would like you to do something different", as opposed to rescue and become over-involved with Patti when she had a problem. By asking this question, it was my intention to promote a perceptual shift in Ruth's thinking, which would then lead to new behavioral patterns between Ruth and Patti. Once an old frame is broken, the family system reorganizes itself and the change process is underway (de Shazer, 1982).

I also assisted Ruth to begin to negotiate rules and expectations with Patti that would meet her needs as an adolescent, as well as meet Ruth's need to guide, nurture and protect. Ruth needed to let go of her over-involvement in Patti's life without letting go of her control. I suggested to Ruth that she could institute a time limit on the telephone or she could get a second telephone line/phone for Patti and split the cost of monthly service. Ruth was to discuss these plans with Patti and work out a solution that was fair and demonstrated co-operation. The second suggestion that I made to Ruth was to talk to Patti about her desire to spend time with Patti during the week. I encouraged Ruth to find some way to sit down with Patti and negotiate one day a week that Ruth would like to spend with Patti at home, talking, watching

television, going for a walk, etc. This suggestion was made to improve the relationship between Ruth and Patti and to decrease conflict. The third suggestion that I made to Ruth was to let Patti know in a respectful way that, if she continued to come in late in the evenings, the next weekend she would have to be in earlier. Ruth identified these areas as concerns. Several other suggestions were made as to what Ruth could do to take control or charge as we addressed the various concerns which Ruth raised throughout this session.

I asked Ruth to show me how she was going to speak to Patti about her areas of concern. Ruth was very soft-spoken, quiet and gentle when she spoke. Ruth realized that Patti would not take her seriously if she attempted to speak to her this way. Ruth and I role played so she could learn to model a more effective way of speaking with Patti. After a few trial runs, Ruth felt comfortable with what she wanted to say to Patti about her areas of concerns.

As treatment progressed, Ruth reported less conflict and an increased ability to negotiate needs. Also, Patti was more respectful towards Ruth. I validated Ruth for all the progress that she had made.

Both Ruth and Patti came to the fourth session. This was not planned, because I was initially told by Ruth that Patti refused to attend therapy. Patti and Ruth appeared relaxed and friendly. Ruth stated that Patti's attitude had improved, she was listening more and was co-operative at home. I

encouraged Patti to continue with her good work, since it allowed Ruth to grant her the freedom which she so clearly wanted. They also reported a more open and direct communication pattern and a more relaxed atmosphere. Patti was attending school daily and was no longer staying out beyond her curfew.

I met with Ruth alone at the end of the session and suggested that perhaps we could meet one more time to review the changes and schedule a check-up appointment six weeks later. It was agreed if the new behaviours had continued, therapy would be terminated at that time.

Sessions Five to Seven:

In session five, Ruth stated that "We are back to square one" because she had kicked Patti out of the house about two weeks ago for being disrespectful. Patti was residing in a group home through Child and Family Services and visited with Ruth a few times a week. According to Ruth, their visits went well and there were no conflicts. Ruth said that Patti had contacted her other times because she wanted cigarettes, money and bus tickets. Ruth had been unable to say "no" to Patti. I asked Ruth "What was different about the week before when things had gone well?" Ruth responded that Patti was co-operative, respectful and more responsible. Ruth also recognized that she was more trusting of Patti and, as a

result, she was able to step back and allow Patti more freedom to demonstrate responsible behaviour. There was also less arguing and nagging.

Watzlawick, Weakland and Fisch (1974) define second order change as a change in the rules governing the system's structure or internal order. A second order intervention introduces a change in the rules governing how decisions are made and implemented, thus altering the system's structure (Lee Combrinck-Graham, 1995). In this family, the change in the family structure remained unaltered, therefore, relapse and further escalation of the problem occurred, not resolution.

It became clear that Ruth continued to have difficulties negotiating and enforcing rules and consequences in specific areas. She also expressed her confusion that she did not seem to know when to intervene with Patti and when to let things go. The rest of the session focused on Ruth identifying specific areas of concern regarding Patti and her expectations in those areas. She identified concerns relating to Patti's attendance and performance at school, curfew, weekly allowance, smoking and the activities of her own chosen peer group. I also encouraged Ruth to explore her support network outside of the home. I suggested that she look into the group called "Parents Without Partners". Ruth did not seem to have many close personal friends. Her support came from one of her married daughters whom Ruth visited at least once a week.

Ruth's ability to develop a support network had been weakened by focusing all of her attention and energy into Patti and neglecting her own needs. This behaviour encouraged over-involvement and the blurring of boundaries between the parental and adolescent subsystem. By reaching out and spending time with friends, Ruth would begin to take care of herself and her own needs. As a result, she would worry less about Patti, and therefore, the boundaries between Patti and Ruth would become clearer.

Over the next two sessions, Ruth and I explored the reasons for her reluctance to talk to Patti about her set of expectations and rules in a firm way. It became evident that Ruth was feeling a deep sense of quilt over being a poor parent. This feeling was particularly strong because Patti was not turning out the way she had hoped. Patti picked at Ruth's guilt and inflamed it by accusing Ruth of being "mean", "unfair" and "stupid" whenever she asserted her parental role. When Ruth tried to impose consequences, Patti screamed, swore at her and threatened to run away. The more Patti humiliated Ruth, the more hopeless and helpless Ruth became. I explained to Ruth that firmness offers protection and support. I suggested that the more she takes charge and shows she was serious, the better. In the long run, this would improve her relationship with her daughter.

A discussion was held about how Patti was attempting to emotionally intimidate Ruth. I outlined to Ruth the abusive

negotiation techniques that Patti had often used to convince Ruth that she was acting like an adult who was either crazy, unreasonable or just plain mean. This technique was used by Patti to arouse guilt in Ruth. I also pointed out to Ruth that when the screaming begins and the defending follows, any hope of communicating ends. Attempting to see each other's point of view was no longer an issue. The argument usually became a battle of wills resulting in a winner and a loser. There was no respect and fairness in the interaction.

I contracted to meet with Ruth for four more sessions to coach her on how she can break the cycle of intimidation that Patti was using to maintain control over the situation. According to Minuchin (1974), "A generational boundary must be established that distinguishes between levels of family hierarchy and clarifies the power each level possesses" (p. 112). Most out-of-control adolescents act as if there was no difference in authority between adults and children and communicate with their parents as equals (Prize, 1996, p. 112).

At this point, I also asked Ruth to promise me that when Patti was returned by Child and Family Services, she would not kick her out of the house when she was disrespectful and verbally abusive to her. This was done to emphasize that Ruth had the right and the ability to exercise more power and control over the situation than Child and Family Services. Child and Family Services contacted me once to inform me that

Patti came into care because Ruth signed a Voluntary Placement Agreement for six months, stating that Patti's behaviours were beyond her control. No other discussion occurred between myself and the Child and Family Services worker.

Sessions Eight and Nine:

Ruth brought Patti to this session without informing me of her plans. Patti continued to live in a receiving home through Child and Family Services. She came to this session because she wanted to go home. I began the session by exploring their current relationship patterns and the actual day-to-day routine and conflicts that would occur when Patti moved home.

Ruth reported that when Patti visited during the week, she was co-operative, more responsible, compliant, and they talked more. They attributed these changes to everyone trying harder. Each member was affirmed and validated for their efforts. I remained skeptical that the changes that both of them told me that they had made did in fact occur. Ruth's description of Patti as co-operative, compliant and responsible reminded me of previous improvements in which Patti behaved better as long as Ruth did not push her too hard and did not place rules and expectations on her. I decided to keep pushing to find out if Patti had better self-control consistent with Ruth's description of her. To get beyond

pretending that Patti could accept parental authority being exercised over her, I asked Ruth to talk about her set of rules and expectations of Patti when she returned home. At this point, Patti began to yell and scream at Ruth, attempting to, once again, convince her mother that she was acting like an adult who was unreasonable, mean and stupid. I wanted to intervene so that I could support Ruth, however, I allowed the interaction to continue because I wanted to observe the family's established pattern and not be drawn into the system by attempting to fill the void left by Ruth. This also guided the therapy system towards becoming equalized, bridging the gap between me and Ruth. Ruth could not gain control of Patti. It was difficult to tell if Patti was trying to dominate everyone or if she was trying to get her mother to take charge of a family that was out of control. Since Ruth had no partner that could assist her with taking charge, I supported her executive authority by commenting on her ability to implement fair rules and expectations of Patti. I also commented that Ruth was behaving like a competent adult and parent. My aim was to help Ruth believe in her own strengths and to feel more powerful within the parental subsystem. My support of Ruth gradually seemed to strengthen her shaky confidence in her own abilities. She was able to stick with her rules and expectations of Patti and not back down from her emotional outburst. Once again, Ruth was complimented on her abilities to make good decisions.

In session nine, I met with Ruth alone. Patti continued to live in a receiving home, but plans were being made to have her return home. This session focused mainly on encouraging Ruth to believe that the wisdom necessary to help Patti lay within her. She had to institute a list of chores and rules and demand respect and co-operation from Patti, not Child and Family Services or the therapist. She was to "fire" Child and Family Services and other agencies and take charge. We also spoke of different strategies and ideas she could implement to take control over different situations. I also helped Ruth to understand that the cliches her daughter threw at her about fairness and being mean need not be responded to with parental guilt. She could let Patti know that she loves her and will consider her opinion, however, as her parent, she has the responsibility to make the final decision.

I was hoping that if Ruth was able to take a firm stand with her daughter, Patti would be placed into a position appropriate for her age and hierarchical status. Also, all of these would clearly show that Ruth was taking charge.

Sessions Ten to Eleven:

I met with Ruth alone. She indicated that Patti had been living at home for the last two weeks. Ruth the stated that there was more mutual respect, they talked "nicer" to each other, they were more thoughtful and considerate, and there

was less "bickering" and "nagging". Since there was a small measure of improvement in family communication and less parent/child conflict, I used this as an entry point to punctuate the exceptions that were happening in former problematic situations. For example, when Ruth behaved differently around the time that Patti would be pushing for an argument or fight, it also altered how Patti responded. Ruth stated that she would not allow herself to be "hooked" when Patti would start to lose control. Instead, Ruth would go for a walk by herself until she calmed down so that she could talk to Patti later. This resulted in Ruth feeling good about her abilities as a parent, which improved her self esteem and motivation to do "more of the same". Ruth also stated that she had instituted a list of chores and rules and Patti was co-operating with her. Ruth felt good about the progress she had been making. She was complimented for her success and encouraged to continue in her current direction.

I met with Ruth alone in session eleven. The emphasis was to build on Ruth taking charge because she seemed more confident and self-assured. However, I was skeptical about the structural changes that seemed to have taken place in this family. I was concerned with the re-emergence of the old patterns as soon as Child and Family Services was no longer involved with the family. As a result, I continued to affirm, support and challenge Ruth to assume parental authority in order to re-organize the family structure and to solidify the

changes that were beginning to happen. According to Colapinto (1995):

> A nurturant approach to the diluted family requires skewing an exploration of 'dysfunctionality' and concentrating instead of locating and exploring the family members' ability to connect to each other as a family... emphasis must be placed on encouraging and sustaining the production of transactional events whereby family members behave as parents, children etc. to each other (Colapinto, 1995, p. 68).

Colapinto (1995) placed emphasis on the appreciation and enhancement of family strengths in treatment with "loosely connected families".

It was my hope that Ruth would begin to break away from the old patterns which created and re-inforced the problem and begin to do "something different" to assert her parental authority. Ruth needed to take a crucial step, which was to get her to let go of her old solutions and do something that was different or unusual for her, just the opposite. As discussed in previous sessions, we again spoke of how it would be most helpful if she were to take charge of her family. Ruth needed to empower herself to make decisions and value her inner strengths that had enabled her to cope with her life transitions.

Session Twelve:

In session twelve, Ruth had told me that she had signed

a three month V.P.A. with Child and Family Services. She wanted Patti to live in a foster home with the hope that she would "smarten up". Once again, our discussion focused on their relationship. I discussed with Ruth that each time she "kicks" her daughter out of the house, she loosens her connection with her. The relationship between the two of them would become increasingly stressed and distant. We also addressed, as previously, the family structures of power, control and hierarchies so that Ruth could regain control in the family in order to deal effectively with Patti's behaviour. In this session, the main emphasis was on the overall parent-child relationship, not just on hierarchy, authority and control.

Ruth was not prepared to have Patti live with her for a while because she found her behaviours stressful and unmanageable. Ruth felt guilty about not being able to parent Patti in a healthy and positive way. This stemmed from her own life experiences in which socialization and gender expectations played a major role. She had been struggling as a single woman for many years, feeling isolated with virtually no support system. I attempted to discourage Ruth from relying too heavily on helping professionals to take over her parenting responsibilities. I asked Ruth if she knew of a friend or a relative that would be willing to assist her with parenting Patti until she felt empowered and confident enough to do it on her own.

Colapinto (1995) and Cloe Madanes (1984) suggest that single parents may want to recruit family members or friends as a "temporary complement" to them who would assist parents with taking charge of an out-of-control adolescent. Ruth later called to inform me that she had asked her daughter and brother-in-law to help her with parenting Patti. She cancelled the V.P.A. with Child and Family Services and Patti was returned to live with Ruth again.

The post-measures were not administered to this family because they did not return for further therapy sessions. I attempted to re-engage the family by telephoning and leaving numerous messages, however, to no avail. A letter was subsequently sent to the family advising that if they did not contact me within a two week time frame their file would be closed and counselling sessions terminated.

The family did not respond to the letter, therefore, the case was closed. Perhaps this family connected up with another system, or the mother may have felt that I did not understand her and her situation. However, given the chaotic and highly conflictual relationships, I predict that this family will be returning for future counselling.

Case Summary and Evaluation:

Since this family did not return for further sessions, I questioned myself often about what I could have done

differently. Did I move too quickly? Did I push too hard? In my enthusiasm to work with this family, did I miss something I should have seen? As I reflect on this case, perhaps it would have been more effective if Patti was invited to therapy. This would have enabled Ruth to practice parenting skills during sessions and for the therapist to deal directly with the parent-child conflict.

This strategy would have also allowed me to interrupt and point out the sequence of their interaction, how they triggered each other and how Ruth always got "sucked in". This in-session intervention would have been immediate and visible. As a result, it may have had more of an impact on Ruth. In addition, meeting with both of them would have expanded my understanding of familial issues. The message Patti would have received by including her in therapy was that her viewpoints were important, regardless of her age, thereby recognizing that her involvement was valid and necessary. Patti's initial reluctance or resistance to therapy may have been due to her inability to express herself without conflict with Ruth. I should have sought Patti's understanding of the problem more vigorously, especially when she came in for the two sessions with Ruth. This may have increased Patti's self esteem and confidence. However, it is important to mention that there are times that parenting issues should not be discussed in front of the adolescent(s). I found that working with parents separately from the adolescent(s) enabled the

parent to feel empowered without "losing face" in front of their adolescent(s).

Since Ruth thought of herself as incompetent and "too soft", perhaps I should have spent more time increasing her belief in her own competence and strengths. When Ruth began to affirm her strengths, perhaps I could have assisted her to activate and use these strengths in the parenting field. Also, I could have explored earlier than in session five to seven why Ruth had difficulty taking charge, as opposed to pushing Ruth to take charge. By exploring Ruth's position earlier, I could have had more information about what was preventing her from taking charge, which might have been helpful in building a solution. At this point, it may have been helpful to explore family of origin experiences with Ruth. Understanding how the presenting complaint can be directly related to patterns from family of origin may have provided Ruth with a visual tool to understand the relationship with Patti and thus begin to change her behaviour.

Case Example 2: Family 'B'

The head of the family was a 27 year old single mother named Karen, who had been separated for two years. Karen had three children: a five year old son, Bobby; a four year old son, Kenny; and her youngest son, a one year old, Tanner.

Source and Reason for Referral:

This family had been referred to New Directions for Children, Youth and Families for family therapy by a play therapist from the Child Development Clinic. She had been seeing Bobby on an individual basis because of his aggressive and non-compliant behaviours at home. Bobby was also volatile and aggressive at daycare. Karen contacted New Directions in August of 1996 because she was concerned about her inability to manage Bobby and Kenny at home and was feeling helpless and defeated. She was also concerned that she was often unable to control her anger and frustration that she sometimes felt towards the children.

This family had previously sought help from Child and Family Services. Karen reported that she was attending a parenting class in her home town, but had to withdraw because of conflict with another member of that group.

Initial Interview Summary:

Karen was working as a home-maker on a part-time basis. Her income was supplemented by social assistance. Karen was hoping to be accepted for an administrative assistant course offered through Red River Community College.

Karen attended the first session. She presented as a very competent, intelligent and resourceful mother who was

having problems managing the children at home. When the children's behaviours were inappropriate, Karen would yell, scream and swear at them to get them to comply. When the children were unable to meet her expectations, Karen would call them "little fuckers" etc. and then a "fight cycle" would ensue between them. Karen found it difficult to talk calmly to Bobby and Kenny. Karen also stated that she often resorted to spanking the children because she did not know what else to do when she became very angry and frustrated at them.

In addition, Karen had considered calling Child and Family Services to gain control of her children when she felt defeated and helpless. She admitted that the constant conflicts and anger between her and the children were having a harmful effect on their family life. Karen said that she wanted to discipline and interact with her children differently but did not know how to bring this about. She confessed that she often felt exhausted and overloaded, which also contributed to her inability to manage her children's behaviours differently when they misbehaved.

Structural Assessment:

The parental and sibling subsystems were unclear and diffuse. Karen was not in the executive position; no one was in charge. This lack of leadership vacillated between Karen moving in and taking an overly rigid stance with the children

and then letting everything go and following a more laissez-faire position. This cycle only added chaos and confusion to their lives. This pattern of being inconsistent and then over-reacting may have been how she handled her other relationships. This pattern also points to lack of communication and poor problem-solving skills.

Karen's inability to take control of her children had created an inversion of the power hierarchy between her and the children. Because Karen often felt isolated and frustrated, she had allowed Bobby to become her support and confidante. This pre-occupation with Karen's needs left Bobby feeling scared, anxious and neglected.

The initial FAM111 (Appendix I) suggested that Karen was under a great deal of stress. The scores seemed to support my impression that Karen's ability to deal with stressors in the present situation was jeopardized by a general sense of hopelessness and despair. She reported significant difficulties on five subscales. These subscales were: role performance, communication, involvement, control, and values and norms. These ratings were consistent with Karen's verbal reports regarding the tension and hostility with her children and her feeling of inadequacy in her roles as a parent and woman. It should be noted that Karen's scores in the social desirability and denial scale fell below forty and thus, call into question the validity of her profile (Skinner et al., 1984).

Karen's problem checklist (Appendix J) at the beginning of therapy showed that she was "extremely dissatisfied" with six areas of her family life. The checklist complimented the initial FAM111 profile and clearly identified where Karen was most concerned.

Treatment Goals:

1. To assist Karen to assume a position of executive leadership in the family, to be able to take charge of her children.
2. To help Karen set clear rules, expectations and consequences with her children before she becomes frustrated and furious at them.
3. To enable Karen to learn less aversive parenting strategies.

Strategies to Implement Goals:

1. To teach Karen how to assert herself appropriately as a parent and a person.
2. To help Karen articulate her expectations of the children during therapy sessions and then help her communicate these expectations to her children without anger and frustration through role plays and discussions.
3. To assist Karen to learn other ways of disciplining the

children by discussing various strategies that she could use with the children that does not include physical methods as a way of obtaining her children's co-operation.

Course of Therapy:

Sessions Two to Three:

I met with Karen alone for six sessions following the initial interview. The sessions focused on parenting issues associated mainly with Bobby and Kenny.

Karen stated that when the children misbehaved, she yelled and screamed at them. If they continued to ignore her, Karen used physical force to gain their compliance. It appeared that when the children behaved and Karen was feeling calm, the children would be like "friends", sharing, talking etc.; then, the next minute, Karen would have to discipline them for disobeying rules and expectations.

I suggested to Karen that she needed to learn to negotiate a middle ground as a way of managing her children's behaviour. Her parenting style took extreme forms. She kept pushing the children away when she was angry and frustrated, but when she felt free-spirited and calm, she was very close to them. This cycle only added chaos and confusion to their lives. The solution focused approach is based on the

assumption that all people have difficulties at times. Difficulties become problematic when (a) people mishandle their difficulties, and (b) apply more of the "same solution" to their difficulties. In Karen's situation, if little screaming did not get her children to do what she saw asking, then she intensified her level of screaming, hoping that it would be the answer. I was attempting to help Karen find different solutions before her difficulties escalated.

I also suggested to Karen that if she continued to threaten to give her children away when they misbehaved, she was not going to get the respect to which she was entitled as a parent. Karen began to understand her own part in the pattern as self-defeating and ineffective because yelling and screaming at the children only made their behaviours more demanding and difficult. Understanding the meaning behind the pattern with the realization that the pattern was self-defeating, enabled Karen an effective, therapeutic entry point, whereby she could now directly focus on defining boundaries more clearly.

I also discussed parenting methods she had used and other parenting strategies that she may want to try with her children. I cautioned Karen about feeling comfortable with her new position before she "switched gears" in her parenting style, as it takes time and effort to define a position that was congruent with her values and beliefs. Karen had to think her positions through very carefully and do it when she felt ready.

Just prior to Karen leaving the session, we discussed a task for her to work on. Since Karen had difficulty controlling her anger, I asked her to rank each day, using a scale of 1 to 9, with 1 being "not angry at all" and 9 being "furious". At the end of the day, Karen was to rank how she felt the day had gone. On days ranked 4 or less, Karen was to keep track of what had gone well or what she was doing to stay below 4, e.g., stepped back to calm down, did not pay attention to all of the children's fighting and arguments, talked to a friend, nurtured herself, other. I assigned this task in order to assist Karen to identify the specific behaviours that were part of the change process. In essence, I asked Karen to do something different when she felt like yelling and screaming at her children when she felt tired. I also asked Karen to let me know what she could be doing instead of yelling and screaming at her children. Then I asked her to scale the quality of her responses and what she needed to do to move it a notch on the scale. The beauty of this model was that Karen was able to define what she needed to do to improve her relationship with her children. According to de Shazer (1985), "Simply, solutions involve doing something different from what was done before that did not work" (p. 123). He further states that "this direct but non-specific intervention offers clients a wide range of possible new behaviours and insures that the chosen behaviour will be something that fits for them and is not outside their

bounds of possibility" (p. 125). This solution focused technique helps parents and children learn that they have mastery over their problems and they can take control and responsibility for their actions.

Sessions Four to Six:

Karen came to the fourth session alone. She informed me that Larry, her common-law partner, moved in with her and the children. Karen said that Larry usually came to her house at a regular time to "crash" after an all-night drinking party or when his girlfriend kicked him out for inconsiderate behaviours. Larry would stay anywhere from a few days to a few weeks. I then asked Karen whether she had ever tried to enlist Larry's support with the children's behaviour. Karen said that Larry was neither willing nor ready to do anything to help her with the children. Additionally, he had a serious problem with alcohol.

At this point, I asked Karen why she had allowed Larry to move in with her and the children. She stated that she "felt lonely" and was longing for someone to fill that emptiness. Also, she was hoping that through giving and being tolerant of his behaviours, she would "win his love and affection".

During my meeting with Karen, I told her that she needed to clarify her relationship with Larry. She needed to confront him about his girlfriends. In addition, she needed

to set limits on his abusive and irresponsible behaviours by establishing a clear position on what she would allow and not allow in the relationship. I emphasized that one clarifies a bottom-line not primarily to change or control the other person, but rather to "preserve the dignity of self".

In the fifth session, Karen appeared much more in control of her life and told me that she had taken a clear position with Larry. She told him that he would have to leave the house if he continued to be irresponsible, abusive and disrespectful towards her and the children. She stated that she was able to do this in a relatively calm and non-blaming way, clarifying that she was beginning to take care of herself. Karen also stated that she discussed her needs and bottom-line with Larry in a neutral place, without the children. When the children followed her upstairs, Karen was able to let the children know that she was going to be fine and that they needed to go downstairs because she had to talk to Larry alone. Issues were being dealt with in the parental subsystem, and the parent-child boundaries were becoming clearer and more defined.

Karen also reported that she had been able to step back and talk to the children without yelling and screaming at them. In addition, she was able to sort out what needed her immediate attention and what could wait. As a result, she became less reactive and more assertive with the children. Karen had finally broken the old pattern by doing "something

different" other than yelling and screaming at the children when she felt tired and exhausted. Furthermore, she was able to say "no" to Larry when he had no place to stay for the night. She, herself, noticed the strength she had shown in breaking the patter. "I can't believe that I said 'no' to Larry!", Karen said.

I believe that Karen was beginning to feel good about herself with increased self-confidence and self esteem. She felt more empowered as a parent in her ability to make realistic rules and enforce them without losing her temper with the children. She also realized that, when she practiced self-control, the children were easier to parent. Therefore, there was less parent-child conflict. By spending more time with her children by playing and having fun, Karen's relationship with them improved. There was a healthier balance in how Karen and her children interacted, which resulted from effort on Karen's part, outside of the sessions. For instance, Karen stated that when she did not raise her voice at her children, she noticed that they also reacted more positively towards her. After Karen went to her room for a few minutes or stepped back to relax, she was able to discuss rules and consequences with her children.

Karen had gone out a few times the past week with her girlfriend and was prepared to continue. I validated Karen in her accomplishments and cautioned her that change occurs slowly and gradually.

I terminated therapy with Karen during the sixth session after summarizing the changes and growth I had seen in her family. We also discussed what "buffers" she had to build in herself to stop her from yelling and screaming at the children when she felt down.

Karen believed that she had been successful in attempting to think and step back before she spoke and found that when she did so, she felt clearer and was able to set consequences that she could enforce. Karen had been able to avoid feeling frustrated and taken advantage of and was much happier with this type of approach.

Karen described how she had continued her personal boundary and relationship clarification work. She stated that she felt somewhat better about herself. However, she did not yet feel good about herself. I cautioned Karen not to try to feel good too soon because the feeling is helpful to her in reminding her that although she has made an excellent start, she has much clarification work ahead of her.

The FAM111 post-test scores (Appendix K) for Karen were within the average range, except for control (62) and role performance (60). These scores may have reflected Karen's continued struggle with the changes in the family structure and the anxiety associated with these changes.

Karen reported increased satisfaction on her problem checklist (Appendix L) between pre- and post- tests. On her initial checklist, Karen was dissatisfied and very

dissatisfied in 10 of the 22 areas listed, including the way she felt about herself. By the end of therapy, Karen reported that she was satisfied with herself and many areas of family life, although she did express dissatisfaction with 5 areas on the problem checklist. Karen was concerned about the yelling and the physical force that she sometimes resorted to with the children when they misbehaved. She continued to struggle between the use of less aversive parenting approaches and the use of physical force against her children, especially when she was tired. My observations supported Karen's reports of change. She appeared to be more relaxed and happy.

Karen forgot to bring in the self-anchored scale to our last session, however, throughout the therapy sessions, she referred to the scale as helpful because it assisted her to identify specific behaviours that were part of the change process.

Case Summary and Evaluation:

Since this was my first case during my practicum placement, I was so nervous that it was interfering with the therapy I was doing with this family. I was constantly afraid of making mistakes and over-concerned with my clinical supervisor's opinion of my work. Even though my clinical supervisor reassured me that I was doing a competent interview with this family, my nervousness was apparent not only to me,

but to the family. As a result, I did not connect on any level with this family in the first session. There was a danger that the family would not return for a second session. Nonetheless, Karen did come back for the second session, but she was somewhat cautious about how much she was going to "open up" because she did not know how I would react.

This experience taught me that, as a therapist, it is important to connect with families on some level no matter how anxious I may be. According to Minuchin and Fishman (1981) "Joining is letting the family know that the therapist understands them and is working with and for them. Only under his protection can the family have the security to explore alternatives, try the unusual, and change. Joining is the glue that holds the therapeutic system together" (p. 32).

Case Example 3: Family 'C'

The family consisted of Kim (40 years), her husband Robert and their two children, Sandra (16 years) and Christopher (7 years).

Source and Reason for Referral:

Kim contacted New Directions for Children, Youth and Families by telephone because she was unable to manage the behaviours of her adolescent daughter, Sandra. Kim stated

that during the last few weeks, Sandra had been skipping school and running away from home. Kim had attempted to locate her but had been unsuccessful. Kim said that she also worried about her daughter's safety and well being on the streets. Kim stated that she and her husband had seen a counsellor through Child and Family Services over the summer months to try and improve their family relationships.

Prior to Sandra running away from home, she was also seen at school by a school counsellor. Recently, however, the social worker through Child and Family Services recommended to Kim that family therapy might be an effective way to resolve their present difficulties with Sandra. Kim said that the social worker's recommendation had prompted her to seek family therapy. When I became involved with this family in March of 1997, no other systems had been involved with them since the summer of 1996.

Initial Interview Summary:

I met with Kim alone because her husband had refused to attend family therapy sessions. According to Kim, he felt that their problem was unsolvable and blamed Sandra for the family problems.

Kim presented in a quiet way with a limited range of affect. When she spoke about Sandra, she sounded bitter and angry. Kim said that her husband often blamed her when Sandra

ran away or did not follow parental expectations. Kim said that she was "fed up" and felt that "nothing could be done". Furthermore, she stated that I could not help the family until Sandra was ready to change. Until she changed, Sandra could live elsewhere. Kim perceived the problem as existing within Sandra. During this discussion, Kim was visibly hurt and frustrated by Sandra's behaviours and she admitted that she wanted Sandra to come home, attend school and be part of the family again. Kim wanted to re-establish a connection with her in a more positive and comfortable way. Kim appeared to care for Sandra, even though she presented a conflictual relationship with her. She did not identify any other concerns or comments on any other problems within the family. Kim came from an Asian background. My hypothesis was that she must have felt shameful and defeated having to bring the problem to an outsider because it meant that she had failed the family. This is one of the common issues for Asian families (Shaw and Ja, 1982). The therapist must be sensitive to this issue to be able to engage the family successfully in treatment.

Structural Assessment:

From a structural standpoint, the conflict in this family appeared to be organized around relationship and developmental issues between Kim and Sandra. When Sandra attempted to

individuate, assert herself and become more autonomous, Kim exerted more power and control over Sandra's behaviours in an attempt to re-establish her parental authority. This further frustrated Sandra's attempts to individuate and she began to run away from home, for a period of anywhere from one week to three months. Sandra's behaviours became a typical response in a repetitive sequence of behaviours. Whenever her relationship with her mother became stressful and difficult, she went back to her friends because she saw them as her only shelter from a parental relationship that appeared to be strict and overprotective. Also, it seemed that Sandra felt on the outside of this family, and in an attempt to feel loved and accepted, was searching for a more stable and emotionally fulfilling relationship with her peers. Kim did not understand that the "stricter" she was with Sandra, the more she was driving her away.

Kim attempted to handle difficulties and anxiety in her relationship with others by cutting them off entirely from the family. Each time she was at odds with someone or the relationship was under stress, her belief was that there were only two options to resolve the problem, either give complete loyalty at individual expense or meet one's own needs and be cut off from the family entirely. If someone did something bad to you, you were not supposed to forget it. The personal boundaries between Kim and Sandra were fused and distant. Therefore, the interactional patterns remained fixed and unchanged.

Each time Sandra spent time at home, Kim was unable to keep anger and blame out of her conversation with her. She reacted with emotional intensity to any topic that was brought up by Sandra. Kim was not able to hear Sandra objectively or take a position without blaming or telling her what to do. The "contagious reactivity" between them was so high that they behaved like "two nervous systems hooked together". She was demanding that Sandra change instead of taking responsibility for her own behaviours and emotional reactions. I was aware that in Asian families, individuation and self-reliance is encouraged and promoted, but it is constantly "tinged with the subconscious knowledge of the relationships and obligations between the individual and other family members" (Shaw & Ja, 1982, p. 224). Therefore, one of my goals was to strengthen the bond or the connection between Sandra and Kim.

As I mentioned earlier, Kim had not indicated any other problems within the family other than Sandra, who had become the focal point for much of the conflict within the family. It was not clear how Sandra had emerged as the focal point within the family since there seemed to be very little conflict within the marital subsystem. Kim seemed not to be focusing on Sandra's behaviours in order to deflect attention away from marital difficulties. It was possible that the marital discords were well hidden.

I was cautious to move into the marital relationship too fast because Kim was very guarded to reveal much information

about her family situation. This was partially attributed to Kim's culture and partially attributed to her resistance to change. I had to be patient and let the process evolve.

The initial FAM111 (Appendix M) showed that Kim identified role performance as a problem, supporting the hypothesis that there was a lack of agreement about role definition and adaptability to new roles in the family life cycle. In addition, the scores of Kim were elevated on control and values and norms. This finding appeared to reflect a failure to perceive and adjust to changing life demands. According to Steinhauer and his colleagues (1984), "changes occur less in response to changing situational demands than on the whim or mood of powerful family members... instability and inconsistency typify such families, and the overall effect is destructive" (p. 83).

The elevated score on values and norms may suggest that the degree of latitude was inappropriate. According to Steinhauer and his colleagues (1984), "the family with a narrow latitude has rules covering most areas of family life, and allows little individual choice" (p. 85). In this family, the parents may have demanded the right to define how individual members should think and feel, a situation which was not compatible with the development of autonomy. Perhaps the implicit rules in this family were either submit and give complete loyalty at individual expense or meet one's own needs and be cut off entirely from the family.

The initial problem checklist (Appendix N) also supports Kim being most concerned by the problem. The relationship between parents and children was rated as very dissatisfied. Affective expression and involvement were rated as dissatisfied. The problem checklist complimented the initial FAM111 profile, and clearly identified where Kim was most concerned.

Treatment Goals:

1. To clarify the boundary between the parental and adolescent subsystem to enable differentiation and to facilitate a connection between family members in a more comfortable way.
2. To assist Kim to see how her own behaviour played a role in shaping her relationship with Sandra.
3. To strengthen the parent-child relationship and improve communication between Kim and Sandra.

Throughout the sessions, I attempted to determine whether conflicts in the marital subsystem undermined the effectiveness of the parental subsystem. If that was my assessment, the fourth treatment goal would have been to enable the parents to resolve their conflicts directly rather than triangulate Sandra. This would have been done to encourage a new definition of the "problem" and a new solution.

Strategies to Implement Goals:

1. To teach Kim how to discuss her concerns and expectations with Sandra without becoming angry and emotionally intense by talking about her existing pattern of communication with Sandra and how it prevented Kim from forming a positive relationship with Sandra. Also, explore what maintains and drives Kim's emotional reactivity each time she interacts with Sandra.
2. To explore the processes between Sandra and Kim so that Kim may learn how her individual behaviours were serving to maintain her present relationship with Sandra.
3. To coach Kim in how to have "fun" with Sandra. This was done to help Kim ease up on Sandra and begin to enjoy her as a person.

Course of Therapy:

Sessions Two to Five:

During these sessions, I attempted to broaden the definition of the problem in the context of the family. My intention was to have Kim begin to recognize how her own behaviours were helping to sustain her conflictual relationship with Sandra. I needed to challenge the client family's structure, symptom and world view.

According to Minuchin and Fishman (1981):

> The techniques of introducing an expanded framework are generally of a cognitive nature. The therapist may point out to family members that their transactions are rule-governed, saying: 'You have been doing the same dysfunctional dance for ten years. I will help you look at things differently. Maybe together, we can find other ways of dancing (Minuchin & Fishman, 1981, p. 198).

This teaches the family to focus on the "whole dance or pattern", not just movements, actions and responses (Minuchin & Fishman, p. 198).

During the fourth session, I asked Kim if she was prepared to make a commitment to improve her relationship with Sandra. Kim said she was not sure if she wanted to reach out to Sandra. She sounded bitter and angry and blamed Sandra for all of the family's problems. I attempted to find out what was fuelling Kim's bitterness and her intense unresolved anger towards Sandra. It became clear that Kim's anxiety and anger was sustained by her daughter not attending school, failing grade eleven and not qualifying for a scholarship that Kim had set aside for her since Sandra was 6 years of age. She felt ashamed by Sandra's behaviours. Kim was concerned about what her friends and community would think and say if they found out that her daughter had been running away from home, skipping school, etc. She felt shame and "loss of face" for losing control of her daughter. According to Shaw and Ja (1982):

> The concepts of shame and loss of face involve not only the exposure of your actions for all to see, but also the withdrawal of the family's, community's, or society's confidence and support... interdependence is so important, the actual or threatened withdrawal of support may shake the individual's basic trust that there will be others to rely upon and raise his or her existential anxiety of being truly alone to face life... the fear of losing face can be a powerful motivating force for conforming to family and societal expectations (Shaw & Ja, 1982, p. 215).

I attempted to shift the focus away from Sandra and had Kim begin to view their problem as no one family member's fault; no one was to blame. Sandra did not deliberately misbehave to upset and punish Kim. Kim did not intentionally use Sandra as a scapegoat. They did not intend to do these things to each other, but they did, as if they had an unspoken agreement. They all contributed to the dysfunctional transactional pattern, which was why the problem was no one's fault.

I also wanted Kim to recognize that the way they related to each other was highly reactive, which created and maintained the problems. Despite their best intentions, their attempts to talk to one another generally deteriorated into angry confrontations. Kim would yell and scream at Sandra in an attempt to get compliance and co-operation from her. When the desired behaviours were not achieved, Kim would become angrier and would attempt to resolve the problem by hitting Sandra or telling her to "get out of the house". The next day or the same day, Sandra would leave home for extended periods

of time (3 weeks to 3 months). Accusations were exchanged, feelings were hurt, and nothing was resolved between them.

I wanted Kim to discover more productive ways of relating with Sandra that improved and maintained the parent-child relationship. Unfortunately, Kim continued to blame Sandra and appeared to have given up almost all hope that her relationship with her could be improved. I felt stuck. I felt that I had little hope left of convincing Kim that her relationship with Sandra could become positive and open only if she made an effort to reach out to her, without blame and anger. Kim seemed to show little recognition of the role that her own behaviours had played in shaping her relationship with Sandra.

I consulted with my clinical supervisor, Bernie Klippenstein. My supervisor pointed out that I needed to increase therapeutic intensity in order to get Kim to "own" her actions. According to Minuchin and Fishman (1981) "once the therapist has observed a family's transactions and learned their accustomed patterns, the goal is to make the family experience the how of their interaction as the beginning of a process leading to change" (p. 118). The question was how to make the family "hear the message" (Minuchin & Fishman, 1981, p. 118). The technique that my supervisor suggested that I use to increase therapeutic intensity was "repetition of message" many times in the course of therapy. Minuchin and Fishman (1981) suggest that "if the therapist refuses to move,

the family is forced to move; that is, there is a re-arrangement around the static therapist... Patterns that in the past have been inflexible must now be modified in order to accommodate to the immovable therapist" (p. 120). In addition, "the therapist can secure unwavering attention to a single issue by describing it again and again in the same phrase, like a litany" (p. 120). "Systems have an inertia that resists change, and repetition is required for re-patterning to occur... therapy is a matter of repetition, in which desired structural changes are pursued in many different ways" (Minuchin & Fishman, 1981, p. 123).

In session five, I kept reframing the difficulties Kim presented as interactional because I wanted Kim to see how they triggered each other. For example, I pointed out to Kim that each time she became angry with Sandra, she would yell at her for all the "unhappiness" in the family, making Sandra feel misunderstood, hurt and frustrated. As things became more heated between Kim and Sandra, Sandra would either leave home for days or weeks, or shut down and not talk to Kim for days. Kim's preferred behaviour in such a situation was to become angrier and act like a dictator, demanding unquestioned compliance from Sandra. This sequence of interaction was repeated each time Kim and Sandra communicated with each other about school, friends, or subjects that were of great concern to Kim.

By reframing Kim's difficulties with Sandra, I wanted Kim

to begin to view her complaints with her daughter in a different light and regard family therapy as a way of changing the repetitive patterns that had brought Kim so much pain and distress. Although the facts of a situation may not change, how they are seen or the context in which they are maintained is different, thereby offering the family new frames with positive and acceptable terms to live with. Once an old frame is broken, the family system re-organizes itself and the change process is underway (de Shazer, 1982). At the end of this session, I asked Kim what she wanted to do. She agreed to remain in therapy and also agreed to look at how she could improve her relationship with Sandra through communication and involvement.

Kim was affirmed for demonstrating her caring and motivation to work on the problems despite the fact that it was difficult to do. Just prior to Kim leaving the session, I discussed a task for her to work on; specifically, the "Do something different" task was assigned for Kim to implement every time she felt the urge to argue, blame and nag Sandra and to do this as soon as she sensed that any conflict or tension was rising. This task was assigned to activate new behaviourial patterns and potential reframes between therapy sessions. I coached Kim how to talk to and listen to Sandra without yelling, blaming and criticizing her. She was encouraged to approach problems with Sandra calmly or with an eye to the "solution" not with intensity and emotional

reactivity. Homework assignments that are action-oriented, specific and consistent with the work done during the session are necessary for the maintenance of successful solutions. Prescribing a task or a directive around the central issue is one of the simplest and quickest ways to change the rules of the relationship (Walters, Carter, Papp and Silverstein, 1988). It immediately provides family members with a new experience in interacting, upsetting their old familiar relationship patterns and opening up new possibilities or solutions (Walters, Carter, Papp and Silverstein, 1988). I also emphasized that when a parent is "too reactive" to the adolescent, the adolescent's normal development is disrupted and the parent-adolescent relationship itself becomes difficult and problematic. Small issues would take on significance beyond what they needed to because the needs of the parents had become more important than the needs of the adolescent for reasonable guidance. I cautioned Kim to pick her battles with Sandra carefully because anything can become an issue if we allow it. She needed to decide which issues were non-negotiable and which she could compromise on with Sandra.

Sessions Six to Nine:

At the beginning of session six, I was informed by Kim that Sandra had been living at home for a week. She reported

that the situation had improved somewhat since the last session. Kim noticed that when she controlled her own behaviours, there was an improvement in the relationship between herself and Sandra. As a result, she had been attempting to monitor her own actions rather than attempting to control Sandra's. I complimented Kim on her courage to try to stay positively connected to Sandra and to learn a new pattern to deal with conflict. Kim also seemed more relaxed and less intense as she spoke about Sandra.

The subsequent sessions were marked with highs and lows whereby Kim would vacillate between making considerable gains in meeting her desired goals, to being very negative and feeling defeated, especially when Sandra was not coming home on a consistent basis. Since Kim sounded discouraged and frustrated, I utilized the "miracle question" in order to both instill hope and to assist in the development of a clearer picture of what the future would look like when the problem was resolved. Kim stated that Sandra would be living at home, that Sandra would be more accepting of Kim's rules and decisions, and that Sandra would spend more time with the family. Kim believed this would lead to a reduction in tension around the home. The miracle question helped Kim to identify the problem happening the most often between herself and Sandra. As a result, it seemed appropriate to look for exceptions to the problem in this relationship. Kim described going for walks as a family, shopping and going out for dinner

as times they got along well. Kim also realized that when she would listen to sandra calmly, they did not argue and fight and subsequently they got along better. Kim found that there were less fights when the interactional sequence around how they communicated changed. I encouraged Kim to do 'more of the same'.

It became evident that the daughter-father relationship was also stressed. Whenever Sandra was at home, her father yelled at her, accusing her of being thoughtless and mean. Kim noted that when her husband yelled at Sandra, she would often feel that she needed to defend and support Sandra. As a result, Kim often ended up with some of the anxiety from the father-daughter relationship by allowing herself to be triangulated. This anxiety stressed her relationship with her husband. We discussed how Kim could pull back and allow her husband to take the lead with Sandra. This was done to assist Kim to de-triangulate from the father-daughter dyad and allow her husband to develop a better relationship with Sandra. Kim was hesitant to allow her husband to be in complete charge of parenting and disciplining of Sandra because she was concerned of her husband's temper. Kim did not want him to undo what she was attempting to accomplish with Sandra. Kim continued to feel the need to protect Sandra from her father. Since I was unable to convince Kim to perceive the problem differently, I shifted focus back to her relationship with Sandra.

As the sessions continued, it became clearer that Kim did not know how to set flexible rules and guidelines with Sandra. Her parenting style fluctuated between being very authoritarian to being "too soft". I assisted Kim to begin to establish a set of rules with Sandra that would be consistent with her need as an adolescent and would also meet Kim's need as a parent to guide and protect. I cautioned Kim that there needed to be a balance between an absence of rules and too many rules. I told Kim that there needed to be enough rules and consequences for disregarding the rules that the home was run in a fair and orderly fashion, but if there were too many rules, attention was on the rule keeping and therefore the enjoyment of living together as members of a family was gone. I also noted that Kim should not allow the enforcement of the rules to get in the way of her relationship with Sandra. I emphasized that the parent-child relationship was permanent, which made it far more important that any rules and consequences under negotiation.

I assisted Kim to specify three basic rules for Sandra. I also challenged Kim to develop a relationship with Sandra that emphasized common interests, mutual respect, spending time together, and talking about life in general. I encouraged Kim to be supportive and respectful with Sandra.

Sessions Ten to Eleven:

Over the next two sessions, I explored with Kim why she

was having problems with letting her husband take more leadership in the family. According to Kim, at the beginning of their marriage she did allow her husband to take responsibility for some things in the family. Over time, Kim felt that he was not doing the job well enough, therefore, she was quick to rescue, take over and fix. She had little capacity to stay in her "skin" and allow him to struggle with the problem. This pattern was repeated often, and I hypothesized that her husband was left with little motivation for negotiating anything with Kim. Once this happened, I assumed that most of her husband's energies were diverted into withdrawing further from providing support and leadership in the family. He continued to remain distant, hoping that Kim would resolve the problems and issues on her own. When her husband did take the lead in parenting Sandra, it was in anger, and he did not do it appropriately. Kim was angry with him because his emotional reactivity towards Sandra was driving her away from the family. Kim would ally with Sandra, which left Kim's husband feeling rejected and hurt.

The rest of the session was spent discussing leadership issues. Kim was the first-born in her family. She had difficulty letting others take the lead. Her husband was the youngest in his family of origin. He had little experience in providing leadership and making decisions. I discussed with Kim how she could allow her husband to practice providing more leadership and making more decisions in one area, only if she

could practice taking a "back seat" and allow him to learn in order that they could stabilize their ability to guide each other. I asked Kim if she could do this for a week, and the next time I saw her, she could let me know how the "experiment" turned out. At the end of session eleven, Kim agreed to try the assigned task in the near future. I commended Kim for her commitment to want to improve her relationship with her husband and Sandra. I also encouraged Kim to identify a support system outside of her family, as she seemed emotionally isolated.

Session Twelve:

I met with Kim alone. She informed me that Sandra had decided to move into her own apartment. She sounded sad and disappointed with Sandra's decision, however, she was able to support Sandra's decision and offered her help and financial assistance towards the move. It seemed that the changes Kim had started to make had grown and solidified through the course of therapy.

Kim felt under stress when she heard about Sandra's decision, however, she did not cut her off emotionally or flare up in anger at her wanting to move out. Instead, Kim was able to stay connected with Sandra in the face of differences. Kim was beginning to develop a less conflictual

and more respectful relationship with Sandra. I commended Kim on her self reliance and her ability to change her interaction with Sandra. We agreed to meet one more time to review what had been accomplished in therapy and what Kim had found most helpful.

Session Thirteen:

During my thirteenth and last session with Kim, I focused on what had been the most helpful aspect of the therapy process. Kim stated that she could talk freely and get 'things off her chest' without being judged or criticized. She also found my suggestions on how to parent adolescents helpful and useful. Also, our discussion on adolescent development enhanced her understanding of identifying normative behaviours that were appropriate to this stage in the family life cycle. I affirmed Kim for the positive changes she had made and encouraged her to practice the new skills she had learned.

The results of the FAM111 post-test (Appendix O) showed that there were significant changes in the family's overall functioning. There was a noteworthy change in Kim's score in task accomplishment, showing that she continued to struggle with organizing and achieving basic developmental and crisis tasks. There was a large change in Kim's scores in the areas of role performance, control and values and norms. These

areas were no longer in the family problem area. Kim's improved scores in the above areas seemed reflective of the changes she had shown during therapy. Kim was beginning to adapt to new roles required in the evolution of the family life cycle. She was more flexible and accepting of individual needs. A surprising finding was that the control subscale had decreased considerably for Kim. The issue of control was discussed in therapy and one of Kim's goals was to be less controlling. As therapy progressed, she became more even in her parenting style. However, she did acknowledge that this was an area with which she was still struggling.

Kim's score on the values and norms subscale appeared indicative of her ability to be able to establish flexible rules that were more acceptable. Also, her scores for values and norms indicated a greater harmony among family members. Kim had the highest scores in which she saw communication and affective expression as problematic areas in the family. These increased scores may reflect Kim's increased dissatisfaction in her relationship with Sandra. There continued to be arguments and power struggles between Sandra and Kim. According to Skinner et al., (1983):

> Such families experience multiple power struggles, since the accumulated resentments which cannot be expressed directly are displaced onto the areas of control, so that the giving of orders or the refusal of obedience becomes the indirect masked means of expressing anger... inevitably, role allocation and task accomplishment suffer, since the lack of effective communication blocks successful problem-solving and guarantees a perpetuation of tension (Skinner et al., 1983, p. 81).

In addition, Kim continued to be uncomfortable with the display of a wide range of emotions. She was able to display anger and other negative emotions effectively, however, she continued to struggle with the expression of positive feelings and empathy (pleasure, joy, etc.).

The problem checklist showed improvements from pre- test to post- test (see Appendix P). Kim's ratings indicated that she was "satisfied" with most areas of family concerns. She moved from "very dissatisfied" to "satisfied" about feeling good about herself. She also felt more "satisfied" with her individual abilities in using appropriate discipline, taking more responsibility, and showing of feelings. She continued to remain "very dissatisfied" about the use of self-control, setting appropriate rules, and being able to discuss "right from wrong" with family members.

Concerns that improved to the "in between" rating, yet still required further change according to Kim, were the expression of positive feelings, sharing of problems with family members, and the use of physical force.

Case Summary and Evaluation:

In this situation, it may have been more effective to have Kim's husband involved in therapy. This would have enabled the father to become more central and involved in the family life. As a result, the parents would have been able to

communicate with each other more openly and honestly with regard to their views and differences about their parenting and leadership styles. This would have allowed Kim to give up some of her responsibilities by giving her husband more authority in the parenting field. Role responsibility would have occurred between parents. The challenge would have been for the parents to parent in their own way and still continue to support one another. Furthermore, by having both Kim and her husband involved in therapy, I would have been able to see their relationship more completely and determine if there were relationship conflicts between them and whether or not Sandra was triangulated into this conflict. Then, my focus of intervention would have been to help the parents resolve their conflict directly, rather than triangulate Sandra.

It also became clear that it would have been helpful to have Sandra attend some of the sessions in order to assist Kim and Sandra to engage with each other in a different, less conflictual manner.

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

The conclusions of this practicum are organized into three areas. These areas are: 1. evaluation of my professional learning; 2. the structural/solution focused approach (integrated model); and 3. similarities and differences between families with young children and adolescents.

Evaluation of My Professional Learning - Conceptual/Perceptual Skills and The Use of Self

Tomm and Wright (1979) refer to perceptual/conceptual skills as those "taking place in the mind of the therapist" (p. 228). Conceptual skills are greatly cognitive and incorporate the therapist's knowledge of family relationships and of the definitions and concepts that are integrated within a specific model.

Perceptual skills include the therapist's ability to make pertinent and accurate observations of family relationships which will influence the identification of the therapeutic goals and interventions (Tomm & Wright, 1979). They suggested that perceptual and conceptual skills, taken together, refer to "what is taking place in the mind of the therapist and in practice they are so integrally interrelated that they are

difficult to separate" (p. 228).

My skill development as a family therapist was primarily guided and assessed through clinical supervision by observing my family therapy sessions behind a one-way mirror, review of video tapes of sessions, both on my own and in consultation with my clinical supervisor, Mr. Bernie Klippenstein. Being coached live by my clinical supervisor behind a one-way mirror was one of the most practical and scariest of all my training experiences. Live supervision was literally on-the-job training because the families were real, and the clinical supervisor was immediately available to provide direction and feedback when I experienced a difficult moment with a family. Initially, this style of supervision left me feeling nervous, anxious and uncomfortable. As a result, I could not make use of my supervisor's direction and feedback. Fortunately, families are resilient and interventions that are ineffective are "merely assimilated by the family without producing change" (Minuchin & Fishman, 1981, p. 3).

Also, at the beginning, I focused so intently on the content I could not see the behavioral sequences. When I watched my clinical supervisor's tapes, I found myself attributing to him an aura of "magical" insight, clarity and understanding in his sessions with families. I now understand that what I was seeing was the therapist's skill at reading process, which was developed from hard work and years of experience.

By the end of my training, I had learned how to gather information by focusing on themes. Instead of "being transported from one plot to another while tracking the family content", I focused on small segments of the family experience (Minuchin & Fishman, 1981). Because family interactions tend to be "isomorphic", concentrating on small areas comprehensively yielded important information about overall family functioning. By focusing on specific themes, I was able to map out structural hypotheses and develop treatment goals that were therapeutically relevant. In addition, as I became less anxious and less consumed about techniques, I could expand the use of self and therefore empower family members to help them make changes in the reorganization of their family.

During training, I also viewed a number of video taped family sessions directed by my clinical supervisor while I attempted to determine the thinking behind his activity. According to Aponte and Van Deusen (1981) "this kind of observation is most useful when the model interview is also accompanied by an analysis of the thinking behind the senior therapist's activity, done in person by the therapist or through recorded commentary" (p. 339). Otherwise, this type of clinical supervision can be more puzzling than informative to the student.

The experience of seeing my clinical supervisor at work helped me understand that therapy is goal-directed and action-

oriented. The therapist actively plans, initiates and directs change. As Colapinto (1983) notes:

> The structural therapist's curiosity is not 'free' but disciplined, organized by his commitment to change. It is the curiosity of the inventor who needs to solve a problem and ask the questions that can lead to a solution... not the curiosity of the explorer who wants to know more and asks all the questions. The structural therapist needs to know about the family's fears, misguided helpfulness, and available resources to be able to challenge existing patterns to promote new ones (Colapinto, 1983, p. 15).

Through all of these training experiences, I became better at identifying dysfunctional patterns, determining treatment goals and then developing skills to achieve the goals. I also became better at examining individual and dyadic processes in the total family context. As Colapinto (1983) states, "the structural therapist needs to learn to perceive reality in terms of complementarity, to view dysfunctional events in one area of the system as matching other events that are happening or not happening somewhere else in the system" (p. 15).

The structural therapists believe that families manifest their functioning in the enactment. Family members re-enact a current dysfunctional interaction among themselves "in the context of the session, in the present, and in relation to the therapist" (Minuchin & Fishman, 1981, p. 79). It is through the use of enactments that dysfunctional family patterns and transactions are revealed and changed. This requires the

therapist's cognitive use of self. According to Minuchin and Fishman (1981) as the therapist "uses himself to transform" the family system, explaining that "a therapist cannot observe and probe from without. He must be a part of a system of interdependent people" (p. 2).

In my training, I learned to explore and develop my technical skills by either allowing a spontaneous interaction to take place between family members or by organizing a scenario in which family members displayed their dysfunctional transactions. In the last situation, I then used my position to modify the family's structure (i.e., boundaries, power, hierarchy). This technique was very difficult for me to develop because I relied heavily on my prepared notes. When the session did not go according to my notes, I did not know what to do about the process that was developing before my eyes. I felt overly anxious and uncomfortable when I could not predict their responses. It was hard for me to allow family interactions to become spontaneous.

However, by the end of my training, I was able to use enactments to gain knowledge about the family's dysfunctional transactional patterns. According to Minuchin and Fishman (1981), "Enactment requires an active therapist who feels comfortable with engaging and mobilizing people whose responses cannot be predicted" (pp. 80 - 81).

I encouraged and used family enactments as I became increasingly more confident about my ability to deal with

"unpredictable" therapeutic situations. In one situation, I sat quietly and watched a mother and daughter enact their established processes. After a period of listening and watching, it seemed to me that there was nothing the mother could say to get her daughter to gain control of her behaviour. After a while, I joined the enactment by aligning myself with the mother, hoping that our alliance would increase her authority. It also conveyed an important message to her that in fact, she was capable of making her daughter behave respectfully towards her. This strategy worked, as the daughter began to settle down.

In some situations, it was difficult for me to assist client families to "hear" how their behaviours have contributed to the dysfunctional patterns of interaction in their whole family. For example, one of my client families included a 16 year old adolescent who had been described by her mother as "defiant" and "irresponsible". The mother wanted to convince me that she had done everything possible for her daughter, insisting that there was nothing more she could do to help change her behaviour. In another instance, the mother wanted me to teach her 15 year old daughter "how to behave responsibly", claiming that there was nothing she could do to help modify her behaviour.

In the first example, eventually, I was able to convince the mother that her daughter might behave more respectfully and responsibly if she changed her own behaviours. By

challenging the family's structure and transactional patterns repeatedly in the course of therapy, the mother was eventually able to recognize how her behaviours contributed to the family's dysfunctional patterns. According to Minuchin and Fishman (1981):

> Single interventions, no matter how inspired, are rarely effective in changing patterns of interaction that have usually gone on for years. Systems have an inertia that resists change, and repetition is required for re-patterning to occur. Therapy is a matter of repetition, in which desired structural changes are pursued in many different ways (Minuchin & Fishman, 1981, p. 123).

In the other instance, I was unable to convince the mother that she needed to change her behaviours to have her daughter behave more respectfully. The mother continued to be in a powerless position, inviting Child and Family Services and other therapists to intervene and set limits for her daughter. My experience with this family demonstrated that with some families, "cognitive constructions per se are rarely powerful enough to spark family change" (Minuchin & Fishman, 1981, p. 117). Perhaps what I needed to do was increase my level of therapeutic intensity with this family. Minuchin and Fishman (1981) state that a therapist sometimes has to depend upon therapeutic intensity rather than truth to make an intervention effective (p. 117).

Unfortunately, I was unable to implement this technique with this family because they did not attend further family

therapy sessions. Reflecting on my personal learning, I saw changes in my skills as a therapist. As I developed my self-confidence and my ability to provide direction in family sessions, I was able to identify and amplify family strengths and convey the message that they had the resources to change and that I could help them. I was prepared to challenge family members firmly and respectfully and increase the level of affective intensity of our actions even though, occasionally, family members would indicate that they had reached their emotional limit. In fact, the practicum experience enabled me to use myself from a more central, participatory position. This allowed me to develop the freedom to be more honest and open with families as people and, consequently, declare my own position on issues more clearly. From this position of leadership, I was able to confront families in a straightforward manner by connecting with and confirming people in a way that supported them on a personal level while directly challenging their behaviour or beliefs. The ability to be empathetic, supportive and confrontative are all part of being a therapist.

I struggled with this initially because it was easier to engage in or to follow monologues rather than highlight the disagreements and the inconsistencies which often characterized the family processes. I was able to uncover conflict and anger more effectively as I progressed through my practicum. I believe that the difficulties which I had in

this area and the initial anxieties associated with joining families were related to my experiences as a student therapist in new situations.

Figley and Nelson (1990) suggest that student therapists are often reluctant to escalate intensity and to expose conflict and they further state that these may be inappropriate techniques for a beginning therapist (p. 229).

My growth as a therapist was also related to my development as a person. Assisting a therapist to actively conduct treatment in a manner that realized all that the therapist is as a person and assisting a therapist to incorporate his own personal qualities into technical interventions with clients were the core processes in expanding the therapist's "use of self" (Aponte & Winter, 1987). In effect, how I relate to clients, set goals, confront them and how I choose to intervene, will be affected by my own values, life experiences, culture and beliefs. Specifically, my personal qualities are tied up with my theory and technical abilities. The practicum experience allowed me to realize that I need to continue the process of establishing a balance on the personal-technical continuum with each client family I will see in the future. According to Aponte and Winter (1987):

> A therapist needs a training process that can effectively focus on both sides of himself, his technical and personal competence, and that helps integrate the two. Clearly, one can manage with less, but the loss of one or

> the other dimension, and the lack of amalgamation of the two, will inhibit the range of skills and, consequently, the clinician's effectiveness (Aponte & Winter, 1987, p. 89).

The Structural/Solution Focused Approach (Integrated Model)

In this practicum, the structural approach was used to assess family functioning and the solution focused approach was utilized to intervene in the family system. It was found that the structural model can be integrated with a solution focused approach. However, my skill accrual of solution focused techniques was inconsistent. I needed more time and experience to be able to apply the solution focused methods consistently to all families. I found that I relied on the structural family therapist concepts more because the model's concepts are more consistent with my thinking and approach than the solution focused approach in understanding families.

By using the structural approach as my primary assessment tool, I was able to sort out and organize the family's former patterns, structures and interactions. As a result, I was able to develop an appreciation and understanding of how the family functions in a systemic manner. Through my practicum experience, I found that it was imperative to have a good assessment and a clear understanding of the problem and dysfunctional patterns prior to intervening in the family system. Without an adequate assessment, it was difficult to assign tasks that fit. de Shazer's concept of fit is

essential to the process of change. If the intervention does not fit with the client's complaint, it is unlikely that different behaviours will be initiated (de Shazer, 1985).

The solution focused model does not articulate a theoretical model that emphasizes assessment. Instead, de Shazer (1985) states that a goal of a solution focused counsellor is to help people find solutions before the difficulties escalate. It is not necessary for the counsellor to know what maintains the client's complaints. All that is required is that the client do something different. Viewed in this way, the therapeutic task becomes one of helping clients discover non-problematic patterns and helping clients to repeat those patterns, thus increasing the frequency of the patterns that include solutions (Berg & Gallagher, 1991). The solution focused approach also suggests that the counsellor makes two maps when constructing an intervention. One map is of the client's version of their complaints or world view. The second map is of how the therapist views the client's analysis. The difference between the two analyses or maps provides the therapist with information which may lead to a solution and provide a structure for designing the intervention (de Shazer, 1985).

These maps seem to suggest that de Shazer does use in-session assessment to evaluate world views, structures, interactional patterns and client motivation (is the client interested in doing something about the complaint). The

therapeutic interventions are based on this assessment. As de Shazer (1985) states:

> It is the fit between the therapist's description of the complaint pattern and form and the map of the intervention which seems central to the process of initiating therapeutic change. That is, the couple describes the problematic behaviour pattern within a certain context/meaning/frame, and then the therapeutic intervention is based on fitting within the same pattern, but with a difference due to the therapist's construction of the problem with a solution in mind (de Shazer, 1985, p. 60).

de Shazer (1991) contends that change is promoted when the meaning or label of the problem was re-negotiated through the use of "language games" and is accomplished by the client reframing the original problem. This re-negotiation of the problem, through the transformation of the meaning, allows the client to normalize it and make the problem more solvable.

From my experiences with all the families, I found that an accurate assessment or understanding of how problems came to exist and what maintained the dysfunctional family structures were important. According to Sluzki (1983) process, structure and world views all have an effect on the development and sustainment of problems. He states that:

> ... symptomatic/problematic behaviours can be said to be contained and anchored by their own participation in circular, self-perpetuating patterns, by their function as re-enforcers and reminders of structural traits, which recursively contribute to maintain them, and by their participation in world view that in tun provide the ideology that supports them (Sluzki, 1983, p. 474).

The information I obtained by accurately assessing dysfunctional patterns and context helped me to develop an appropriate direction and tasks that fit with the family situation or world view. It provided me with a view and understanding of how families functioned prior to the resolution of the problem and the changes that occurred during treatment.

The two approaches seem to compliment each other. The structural model and its concepts provide a context which allows the therapist to assess the family's interaction and description of the problem. The solution focused model provides a way to use this information to promote change and co-operation.

Both models can provide a family therapist with a way of thinking, understanding and intervening with families. According to Brodovsky (1991) "in the same way a road map and a topological map can be of the same location but provide different information, and thus a different perspective of the same place" (p. 158).

All the therapeutic models utilized in this practicum are but some of the 'constructs' used by therapists in order to understand where the families are and provide some ideas regarding the direction for the work to go (Brodovsky, 1991). To exclude one model at the expense of the other can be much the same as viewing a scene through a narrow lens. According to Brodovsky (1991) "lenses can filter out portions of the

visible spectrum, depth of field, or the surrounding scenery which provides the context for what one sees" (p. 158).

Expanding the lens to other models and points of view gives therapists a more informed view of the therapeutic process. Overall, I found the integrated approach to be an effective way to work with adolescents and their families. The approach builds on clients' strengths and is supportive and validating. It provided mutual respect between families and the therapist. While this framework gave me a well-organized way for classifying families in general, I discovered that families have many things in common and that families are also very different from each other. This finding taught me that I must learn to listen to families and allow their stories to unfold.

As my placement progressed, I learned to work with families more spontaneously, tailoring techniques and interventions to specific family situations. At the end of my practicum experience, I felt that I had made a successful start to my understanding of families, their special issues and how I could work within a more positive and productive manner.

Similarities and Differences Between Families with Young Children and Adolescents

It appears that families with young children and

adolescents struggle with similar issues or problems. These issues were: parenting skills, control, involvement, and communication. The families that I had seen with young children wanted more education and information on normal child development and functioning than families with adolescents. They wanted to be reassured that what they were doing was respectful and was meeting the needs of their young children. It is important to keep in mind that as families with young children move through time, the structure needs to change to accommodate its changing needs. Children grow up and leave, adults grow older, not only facing their own aging process, but their parents aging process. As these changes take place, boundaries need to be redrawn and subsystems regrouped. Adaptation to new circumstances require the family to make a shift in the organization and structure. This process involves varying degrees of stress and tension for all families. The ability to adapt and utilize new ways of coping, providing for each individual's growth without sacrificing the continuity of the family, is the criteria for judging how a family adapts to the change.

Therefore, it is not the absence or presence of problems or issues that indicates effective or ineffective functioning, but how the family copes with the problem and whether or not it is effective and adaptive.

Treatment Outcomes for Other Families

A total of thirteen families were offered family therapy services during this practicum. Five families declined services after the initial telephone contact because they secured services elsewhere or the problems for which they had sought therapy were much better. Two of the families declined further services after the initial interview. Five families were seen until the completion of treatment.

The one family that interrupted treatment after the sixth session was headed by a single mother. My assumption was that she may have felt misunderstood because I challenged her world view.

The experience that I had with two families over missed appointments was a common problem that I encountered with a number of families. It seemed that when there was a family crisis, parents would be very willing to meet with me. However, when things within the family were perceived by them to be running smoothly, there was no need for contact with others outside of the family system.

The families that completed therapy showed significant improvements in all areas at post-test in all dimensions of scores on the FAM111. At the end of therapy, family members showed a more functional relational pattern than during therapy sessions. Aponte and Van Deusen (1981) noted that "these in-session behaviours suggested that the families had

made the necessary second-order organizational change, a crucial measure of positive outcome in structural family therapy" (p. 341). The reports given by family members on the Problem Checklists also indicated improvements in all areas of family functioning.

Client Feedback Form

I conducted termination interviews with three families. I asked questions of each family member about my qualities as a therapist and how each family member perceived the therapeutic services given. Family members reported that they felt validated, supported and heard in therapy.

Overall, families found the intervention used helpful because it built of their co-operation, strengths and positive experiences. The tasks given were found to be useful when it fit with both the problem and the compliments. In the majority of the cases, when a family was complimented on one of its strengths, the family increased its efforts in that direction and therefore, the family carried out what was assigned. The families believed I had an understanding and they were more willing to try something different. There were two families that felt that they still needed to learn new ways of solving their problems and were unable to see their future in a positive way.

I found myself anxiously awaiting the results of the

client feedback forms. In each case, the comments from families were largely 'satisfied' with the therapist and the level of services they had received.

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APPENDIX A:

GENERAL SCALE SAMPLE STATEMENTS

AND

FAM GENERAL SCALE

SAMPLE STATEMENTS FROM THE FAMILY ASSESSMENT MEASURE[1] GENERAL SCALE

The General Scale of the Family Assessment Measure is made up of fifty statements comprising nine subscales. Respondents are asked to indicate a specific level of agreement or disagreement with each statement; each response is then assigned a numerical value. The values of the statements within each subscale are added together to obtain a raw numerical score. These scores are converted into standard scores and the results are then charted to obtain a FAM profile for each respondent. An overall rating of family functioning is obtained for each respondent by adding the totals of his/her subscale scores (excluding the response style subscales of defensiveness and social desirability) and dividing this sum by seven.

Sample statements from each of the nine FAM 111 subscales are presented below:

Task Accomplishment:
When problems come up we try different ways of solving them.

Role Performance:
My family expects me to do more than my share.

Communication:
We argue about who said what in our family.

Affective Expression:
We tell each other about things that bother us.

Involvement:
We feel loved in our family.

Control:
Punishments are fair in our family.

Values and Norms:
The rules in our family don't make sense.

Social Desirability:
My family and I understand each other completely.

Defensiveness:
Sometimes we are unfair to each other.

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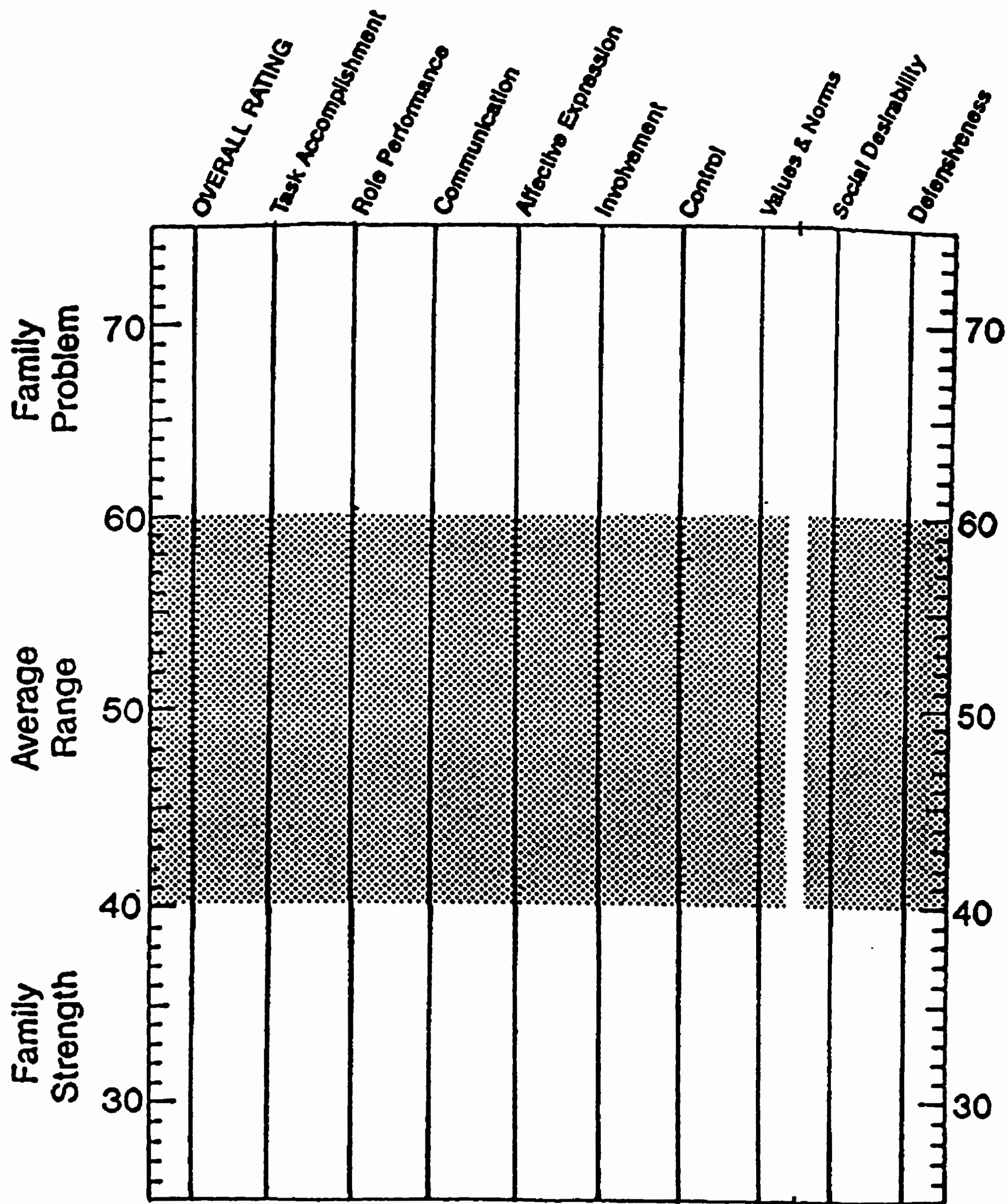
[1]Copyright 1984, Harvey A. Skinner, Paul D. Steinhauer, Jack Santa-Barbara. See also, Skinner et al., 1983; Steinhauer et al., 1984.


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
70
60
50
40
30

APPENDIX B:

PROBLEM CHECKLIST

Problem Checklist

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)					
2.	Sharing feelings like anger, sadness, hurt, etc.					
3.	Sharing problems with the family					
4.	Making sensible rules					
5.	Being able to discuss what is right and wrong					
6.	Sharing of responsibilities					
7.	Handling anger and frustration					
8.	Dealing with matters concerning sex					
9.	Proper use of alcohol, drugs					
10.	Use of discipline					
11.	Use of physical force					
12.	The amount of independence you have in the family					
13.	Making contact with friends, relatives, church, etc.					
14.	Relationship between parents					
15.	Relationship between children					
16.	Relationship between parents and children					
17.	Time family members spend together					
18.	Situation at work or school					
19.	Family finances					
20.	Housing situation					

21.	Overall satisfaction with my family					

Make the last rating for yourself:

22.	Feeling good about myself					

NAME:____________________ Date:________________

APPENDIX C:

ANGER RATING SCALE

ANGER RATING SCALE

Week of (during Therapy):______________________________

At the end of the day, please record your feelings for the entire day.

Date:______________

1	2	3	4	5	6	7	8	9
Not Angry At All		Moderately Angry			Very Angry			Furious

Things I did to stay below '4' (please place a check mark on the line that applies):

______ Stepped back to calm down.

______ Did not pay attention to all of my children's fights and arguments.

______ Talked to a friend.

______ Nurtured myself (i.e. took a bath, went to a movie, went to the Spa).

______ Other:______________________________________

____

____

____

____

____

APPENDIX D:

BED WETTING RATING SCALE

BED WETTING SCALE

Please circle the appropriate response:

Bed Wetting BEFORE Therapy:

1	2	3	4	5	6	7
Rarely	Very Infrequently	Infrequently	Neutral	Often	Very Frequently	All the Time

Bed Wetting DURING Therapy:

1	2	3	4	5	6	7
Rarely	Very Infrequently	Infrequently	Neutral	Often	Very Frequently	All the Time

Bed Wetting AFTER Therapy:

1	2	3	4	5	6	7
Rarely	Very Infrequently	Infrequently	Neutral	Often	Very Frequently	All the Time

APPENDIX E:

ANXIETY RATING SCALE

ANXIETY RATING SCALE

Please place a check mark in the appropriate place.

As a result of therapy, were they:

		BETTER	UNCHANGED	WORSE
1.	Nightmares	________	________	________
2.	Being fearful and upset of things going wrong	________	________	________
3.	Afraid to use the toilet	________	________	________

Other comments:

____

____

____

____

____

APPENDIX F:

LETTER OF AUTHORIZATION

AND

CLIENT FEEDBACK FORM

This is to verify that Maria Owens has the permission of New Dierctions for Children, Youth and Families to reprint, use for illustrative purposes or any other purpose connected to her practicum, the Consumer Feedback form and any other forms developed by New Directions.

Bernie Klippenstein
Family Therapy Department
on authority of
Chris Cassels, ClinicalDirector

400-777 Portage Avenue Winnipeg, Manitoba, Canada R3G 0N3
Telephone: (204) 786-7051 Fax: (204) 774-6468 TTY: (204) 774-8541

• Families Affected by Sexual Assault • Family Therapy • Manitoba Learning Centre • Parent Support • Project Opikihiwawin
• Community Treatment Centres • Resources for Adolescent Parents (RAP) • Resources for Women • Services for the Multi-handicapped (SMH)
• Training and Employment Resources for Females (TERF) • Training Resources for Youth (TRY)
• Treatment Resources and Individualized Living Supports (TRAILS)

NEW DIRECTIONS FOR CHILDREN, YOUTH AND FAMILIES

Family Therapy Department

Client Feedback Form

We are interested in your honest opinions of the service your family received from the Family Therapy Department. Please read the following questions and circle the answer below each question which is closest to your feelings.

1. How easy was it for your family to get service?

Very Easy	Easy	Difficult	Very Difficult

2. To what extent did our service meet the needs of your family?

Almost all of our needs were met	Most of our needs were met	Only a few of our needs were met	None of our needs were met

3. To what extent were you satisfied with your therapist?

Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied

4. How would you rate the quality of service?

Excellent	Good	Fair	Poor

5. To what extent did your family change?

A great deal	A fair amount	Very little	No change

6. Did your family situation improve?

Much Improvement	Some Improvement	No Improvement	More of a Problem

7. Did things get better for you personally?

Not at all	Very little	A fair amount	A great deal

8. If you were to seek help again, would you use our service?

   Definitely no **I don't think** **I think so** **Definitely yes**

9. If you or your family were involved with other helpers in addition to our service, how satisfied were you with the way your therapist worked with the other helpers?

   Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied**

10. How would you describe the therapist? Would you say she was caring, non-judgemental and comfortable?

    ____

    ____

    ____

11. What did the therapist do that worked for your family?

    ____

    ____

    ____

12. What did the therapist do that did not help?

    ____

    ____

    ____

13. What was the most helpful aspect of the therapy process?

    ____

    ____

    ____

14. Did the assigned tasks fit with your family's world view?

____

____

____

15. Were the tasks helpful?

____

____

____

16. Did you find questions about your past successes helpful?

____

____

____

17. Did you find the exception questions trivializing and repetitious?

____

____

____

18. Did the 'miracle question' help you with the identification of treatment goals?

____

____

____

19. Did you feel the 'miracle question' was appropriately used by the therapist?

____

____

____

20. Were solutions clearly defined?

____

____

____

21. Please feel free to use this space to write any additional comments or suggestions you would like to make:

____

____

____

____

____

____

____

____

____

____

____

____

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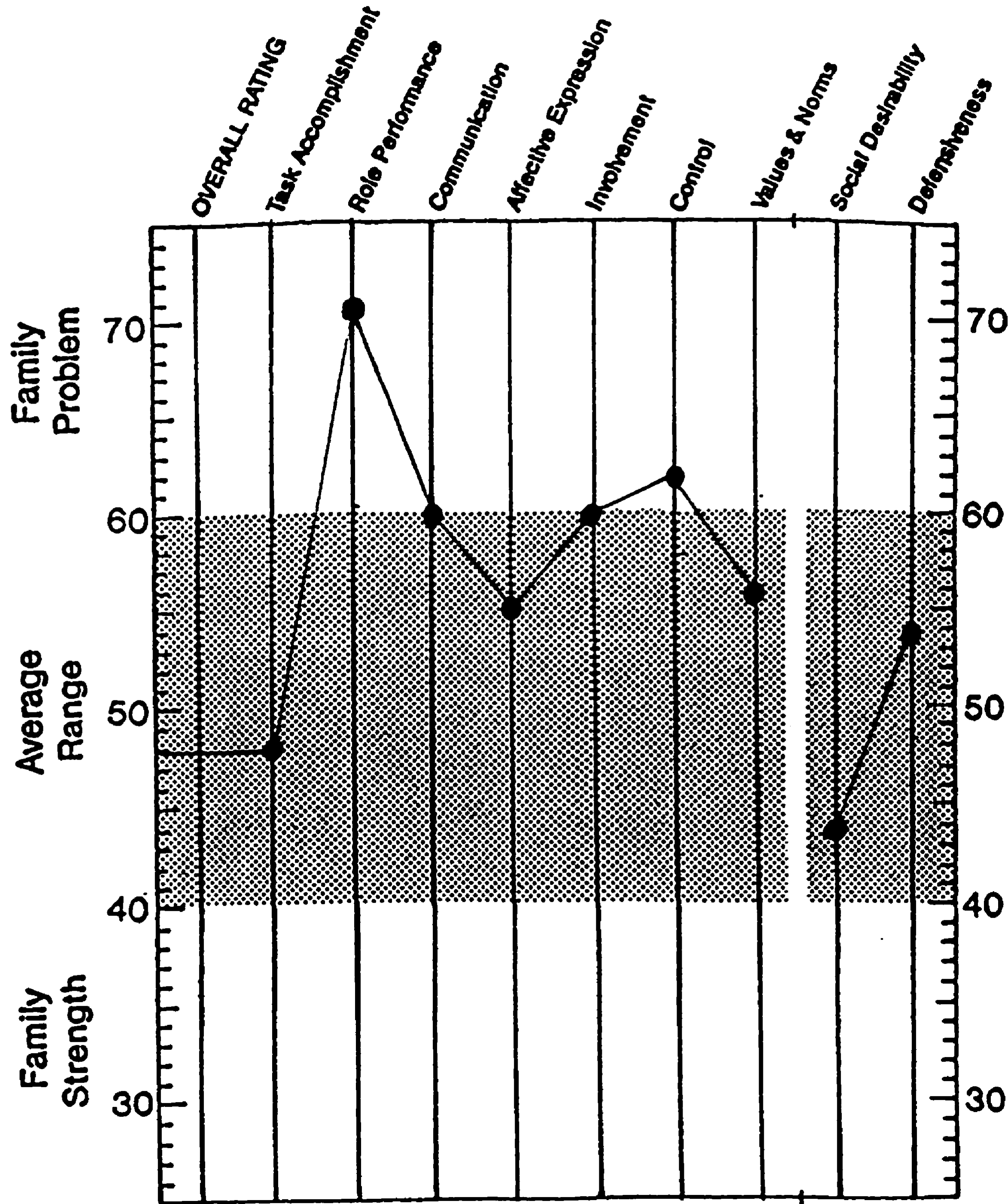
____

APPENDIX G:

FAMILY 'A' PRE-TEST FAM111 PROFILE

FAMILY 'A' PRE-TEST FAM111 PROFILE



RUTH

APPENDIX H:

PROBLEM CHECKLIST - FAMILY 'A' PRE-TEST

Problem Checklist: Ruth - Family "A" Pre-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)			X		
2.	Sharing feelings like anger, sadness, hurt, etc.		X			
3.	Sharing problems with the family			X		
4.	Making sensible rules		X			
5.	Being able to discuss what is right and wrong		X			
6.	Sharing of responsibilities		X			
7.	Handling anger and frustration			X		
8.	Dealing with matters concerning sex		X			
9.	Proper use of alcohol, drugs				X	
10.	Use of discipline			X		
11.	Use of physical force					X
12.	The amount of independence you have in the family					X
13.	Making contact with friends, relatives, church, etc.			X		
14.	Relationship between parents			X		
15.	Relationship between children			X		
16.	Relationship between parents and children			X		
17.	Time family members spend together		X			
18.	Situation at work or school		X			
19.	Family finances		X			
20.	Housing situation				X	

21.	Overall satisfaction with my family			X		

Make the last rating for yourself:

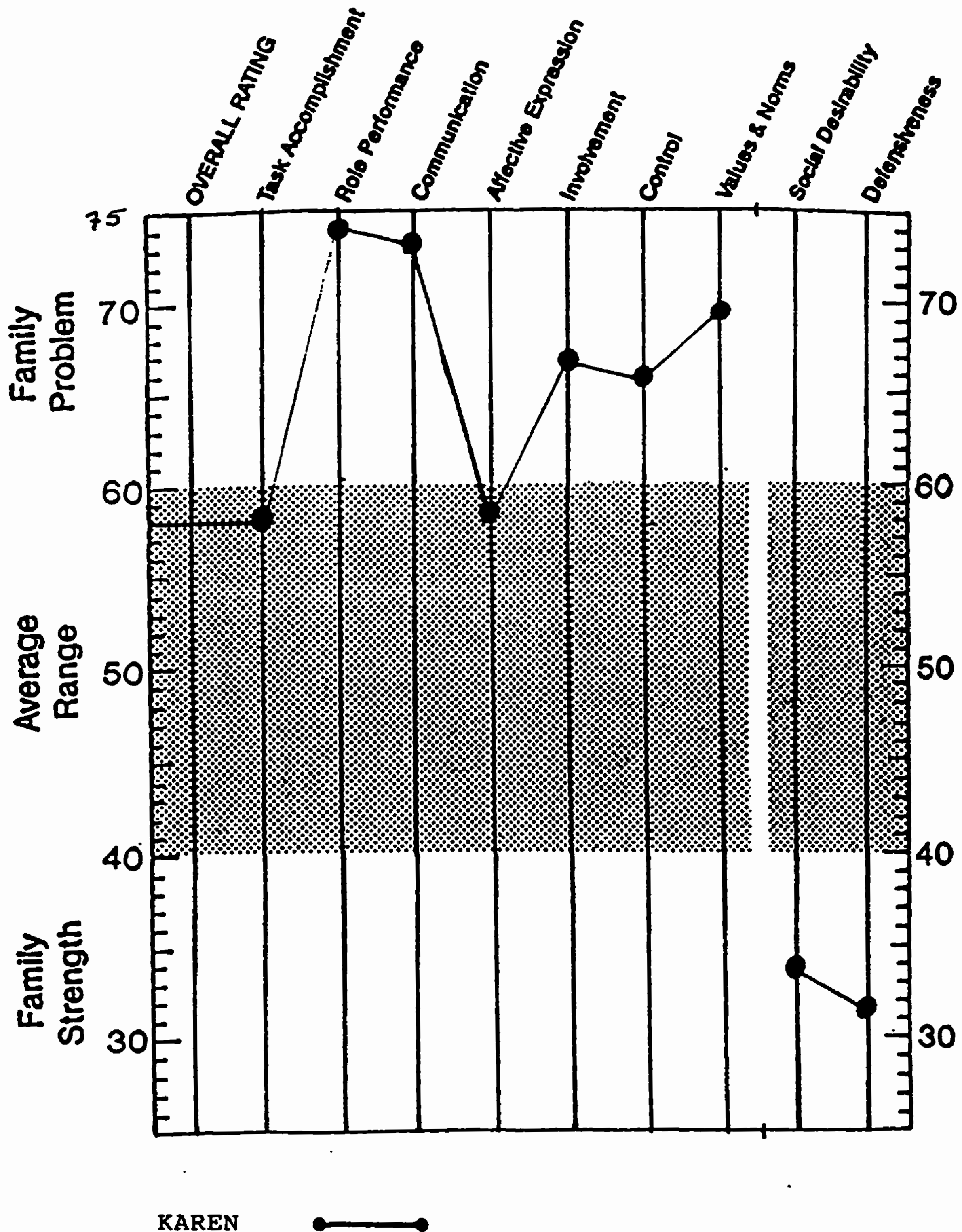
22.	Feeling good about myself			X		

NAME: Ruth Date: March 20/1997

APPENDIX I:

FAMILY 'B' PRE-TEST FAM111 PROFILE

FAMILY 'B' PRE-TEST FAM111 PROFILE



KAREN

APPENDIX J:

PROBLEM CHECKLIST - FAMILY 'B' PRE-TEST

Problem Checklist: Karen - Family "B" - Pre-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)			X		
2.	Sharing feelings like anger, sadness, hurt, etc.	X				
3.	Sharing problems with the family				X	
4.	Making sensible rules		X			
5.	Being able to discuss what is right and wrong				X	
6.	Sharing of responsibilities	X				
7.	Handling anger and frustration	XX				
8.	Dealing with matters concerning sex					X
9.	Proper use of alcohol, drugs					X
10.	Use of discipline	X				
11.	Use of physical force	X				
12.	The amount of independence you have in the family	X				
13.	Making contact with friends, relatives, church, etc.			X		
14.	Relationship between parents					
15.	Relationship between children		X			
16.	Relationship between parents and children		X			
17.	Time family members spend together					X
18.	Situation at work or school					X
19.	Family finances		X			
20.	Housing situation					X

21.	Overall satisfaction with my family			X		

Make the last rating for yourself:

22.	Feeling good about myself		X			

NAME: Karen Date: December 7/1996

APPENDIX K:

FAMILY 'B' POST-TEST SCORES ON FAM111

FAMILY 'B' POST-TEST FAM111 PROFILE

FAM GENERAL SCALE

OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness

Family Problem

Average Range

Family Strength

70
60
50
40
30

KAREN

APPENDIX L:

PROBLEM CHECKLIST - FAMILY 'B' POST-TEST

Problem Checklist: Karen - Family "B" Post-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)				X	
2.	Sharing feelings like anger, sadness, hurt, etc.			X		
3.	Sharing problems with the family				X	
4.	Making sensible rules				X	
5.	Being able to discuss what is right and wrong			X		
6.	Sharing of responsibilities		X			
7.	Handling anger and frustration			X		
8.	Dealing with matters concerning sex			X		
9.	Proper use of alcohol, drugs				X	
10.	Use of discipline		X			
11.	Use of physical force		X			
12.	The amount of independence you have in the family			X		
13.	Making contact with friends, relatives, church, etc.				X	
14.	Relationship between parents		X			
15.	Relationship between children			X		
16.	Relationship between parents and children			X		
17.	Time family members spend together		X			
18.	Situation at work or school				X	
19.	Family finances				X	
20.	Housing situation					X

21.	Overall satisfaction with my family				X	

Make the last rating for yourself:

22.	Feeling good about myself				X	

NAME: Karen Date: May 13/1997

APPENDIX M:

FAMILY 'C' PRE-TEST FAM111 PROFILE

FAMILY 'C' PRE-TEST FAM111 PROFILE

FAM GENERAL SCALE

OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness

Family Problem
Average Range
Family Strength

70
60
50
40
30

KIM

APPENDIX N:

PROBLEM CHECKLIST - FAMILY 'C' PRE-TEST

Problem Checklist: Kim - Family "C" - Pre-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)		X			
2.	Sharing feelings like anger, sadness, hurt, etc.			X		
3.	Sharing problems with the family				X	
4.	Making sensible rules					X
5.	Being able to discuss what is right and wrong	X				
6.	Sharing of responsibilities	X				
7.	Handling anger and frustration			X		
8.	Dealing with matters concerning sex	X				
9.	Proper use of alcohol, drugs				X	
10.	Use of discipline					X
11.	Use of physical force	X				
12.	The amount of independence you have in the family	X				
13.	Making contact with friends, relatives, church, etc.				X	
14.	Relationship between parents			X		
15.	Relationship between children			X		
16.	Relationship between parents and children	X				
17.	Time family members spend together	X				
18.	Situation at work or school	X				
19.	Family finances			X		
20.	Housing situation	X				

21.	Overall satisfaction with my family	X				

Make the last rating for yourself:

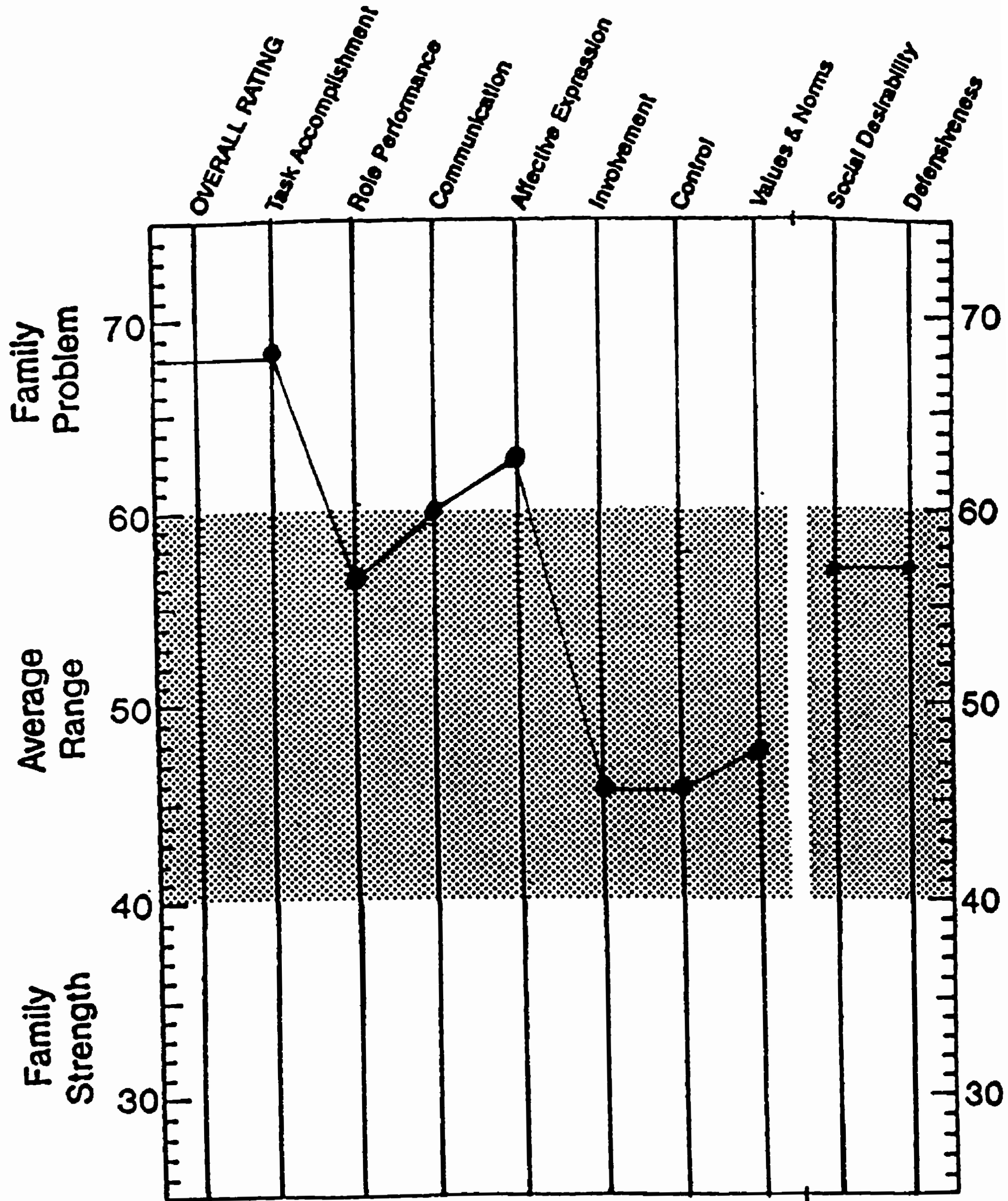
22.	Feeling good about myself	X				

NAME: Kim Date: March 11/1997

APPENDIX O:

FAMILY 'C' POST-TEST SCORES ON FAM111

FAMILY 'C' POST-TEST FAM111 PROFILE



APPENDIX P:

PROBLEM CHECKLIST FAMILY 'C' POST-TEST

Problem Checklist: Kim - Family "C" - Post-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)			X		
2.	Sharing feelings like anger, sadness, hurt, etc.				X	
3.	Sharing problems with the family			X		
4.	Making sensible rules					X
5.	Being able to discuss what is right and wrong					X
6.	Sharing of responsibilities				X	
7.	Handling anger and frustration					X
8.	Dealing with matters concerning sex				X	
9.	Proper use of alcohol, drugs				X	
10.	Use of discipline				X	
11.	Use of physical force			X		
12.	The amount of independence you have in the family				X	
13.	Making contact with friends, relatives, church, etc.				X	
14.	Relationship between parents			X		
15.	Relationship between children		X			
16.	Relationship between parents and children	X				
17.	Time family members spend together			X		
18.	Situation at work or school				X	
19.	Family finances				X	
20.	Housing situation			X		

21.	Overall satisfaction with my family			X		

Make the last rating for yourself:

22.	Feeling good about myself				X	

NAME: Kim Date: August 31/1997

APPENDIX: Q

FAMILY FOUR

Family 'O'

Family 'O' was a single parent family comprised of Sharon, age 35, Jessica, age 7, and Jeena, age 5. Sharon had separated from her husband about 3 years ago because he was physically and verbally abusive with her and the girls. Jeena had regular, supervised visits with her father, Gerald. Jessica was excluded from these visits because Gerald is not her biological father.

Sharon contacted New Directions for Children, Youth and Families. She was concerned about Jeena, whose behaviours had been regressing since supervised visits began with Gerald. She was also worried about Jessica who 'cried a lot' because she was excluded from the visitations with Gerald.

Intervention with the family focused on detriangulating Jeena from the parental subsystem and putting Sharon in charge of helping the children cope with the visits. The second goal was to explore why Sharon was still angry with Gerald and why the battle continued to be unresolved. A contract for four sessions was negotiated with Sharon. As the sessions continued, Sharon was able to recognize how Jeena was triangulated between her and Gerald and how she continued to feel the need to shift her loyalty between them in order to balance her sense of psychological and emotional attachment with each parent. She realized that her children need and deserve to be allowed to love both parents without having to take sides. Sharon also began to directly address her anger

and hurt which kept her caught up in a negative relationship with Gerald. She acknowledged that this anger and emotional hostility often got transmitted to the children. As Sharon continued to work through these difficult issues, she became more open and honest in her communication with her children about the divorce, feelings etc. Therefore, the parent-child relationship had been strengthened.

The outcome results of the measurements are included with this appendix. The measurements show significant improvement in all areas of family functioning. Sharon also completed a self-anchored scale on Jeena's bedwetting behaviour. According to Sharon, Jeena's bedwetting behaviour occurred 'very infrequently' after family therapy. The 'bedwetting rating scale' is also included in the appendix.

FAMILY 'O' PRE-TEST FAM111 PROFILE

FAM GENERAL SCALE

OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness

Family Problem
Average Range
Family Strength

70
60
50
40
30

SHARON

FAMILY 'O' POST-TEST FAM111 PROFILE

FAM GENERAL SCALE

OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness

Family Problem
Average Range
Family Strength

70
60
50
40
30

SHARON

Problem Checklist: Sharon - Family "O" - Pre-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)			X		
2.	Sharing feelings like anger, sadness, hurt, etc.	X				
3.	Sharing problems with the family		X			
4.	Making sensible rules			X		
5.	Being able to discuss what is right and wrong				X	
6.	Sharing of responsibilities			X		
7.	Handling anger and frustration	X				
8.	Dealing with matters concerning sex				X	
9.	Proper use of alcohol, drugs				X	
10.	Use of discipline			X		
11.	Use of physical force				X	
12.	The amount of independence you have in the family			X		
13.	Making contact with friends, relatives, church, etc.			X		
14.	Relationship between parents		X			
15.	Relationship between children		X			
16.	Relationship between parents and children		X			
17.	Time family members spend together				X	
18.	Situation at work or school				X	
19.	Family finances			X		
20.	Housing situation			X		

21.	Overall satisfaction with my family			X		

Make the last rating for yourself:

22.	Feeling good about myself			X		

NAME: Sharon Date: October 23/1996

Problem Checklist: Sharon - Family "O" - Post-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)				X	
2.	Sharing feelings like anger, sadness, hurt, etc.			X		
3.	Sharing problems with the family				X	
4.	Making sensible rules				X	
5.	Being able to discuss what is right and wrong				X	
6.	Sharing of responsibilities			X		
7.	Handling anger and frustration			X		
8.	Dealing with matters concerning sex				X	
9.	Proper use of alcohol, drugs				X	
10.	Use of discipline				X	
11.	Use of physical force				X	
12.	The amount of independence you have in the family			X		
13.	Making contact with friends, relatives, church, etc.			X		
14.	Relationship between parents		X			
15.	Relationship between children			X		
16.	Relationship between parents and children		X			
17.	Time family members spend together				X	
18.	Situation at work or school				X	
19.	Family finances			X		
20.	Housing situation			X		

21.	Overall satisfaction with my family				X	

Make the last rating for yourself:

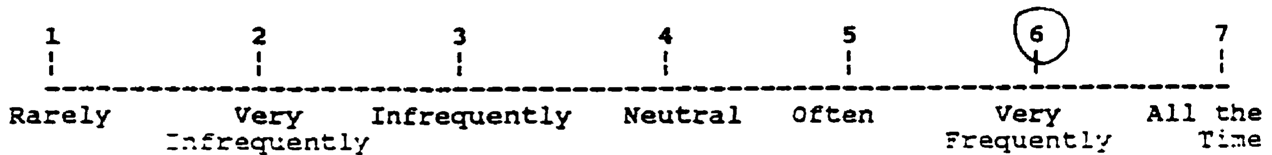
22.	Feeling good about myself				X	

NAME: Sharon Date: February 6/1997

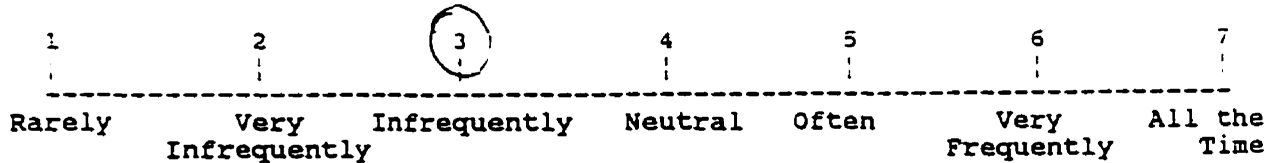
BED WETTING SCALE

Please circle the appropriate response:

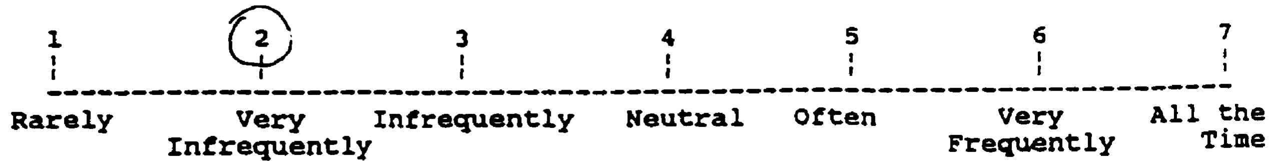
Bed Wetting BEFORE Therapy:



Bed Wetting DURING Therapy:



Bed Wetting AFTER Therapy:



APPENDIX: R

FAMILY FIVE

Family 'P'

Family 'P' was a two parent, blended family consisting of the natural mother, Heather, age 23 and her common-law spouse, Gary, age 25. Heather had a three year old son, Cole, from a previous relationship. Heather and Gary had been together for about one year.

This case was a self-referral by Heather. She was concerned about her son visiting with his natural father. Since the visitations began, Cole had been very fearful and anxious whenever anything went wrong. She wanted assistance with how to help Cole get over his fears and anxieties.

In the first session, I learned that Cole had made sexual abuse allegations against his natural father. Child and Family Services did an abuse investigation and found no evidence of sexual abuse. A medical examination was also completed and no evidence of sexual abuse was found. Since Heather was very anxious about the alleged sexual abuse, visitations with the natural father were terminated by the Court system. A report by an independent assessor was completed, recommending that it would be in Cole's best interest at this time, not to have visits with his natural father.

I gave Heather and Gary information on child development, including age-appropriate childhood sexuality because they were very worried and uncertain about what behaviours they should pay attention to and what behaviours were normal for a

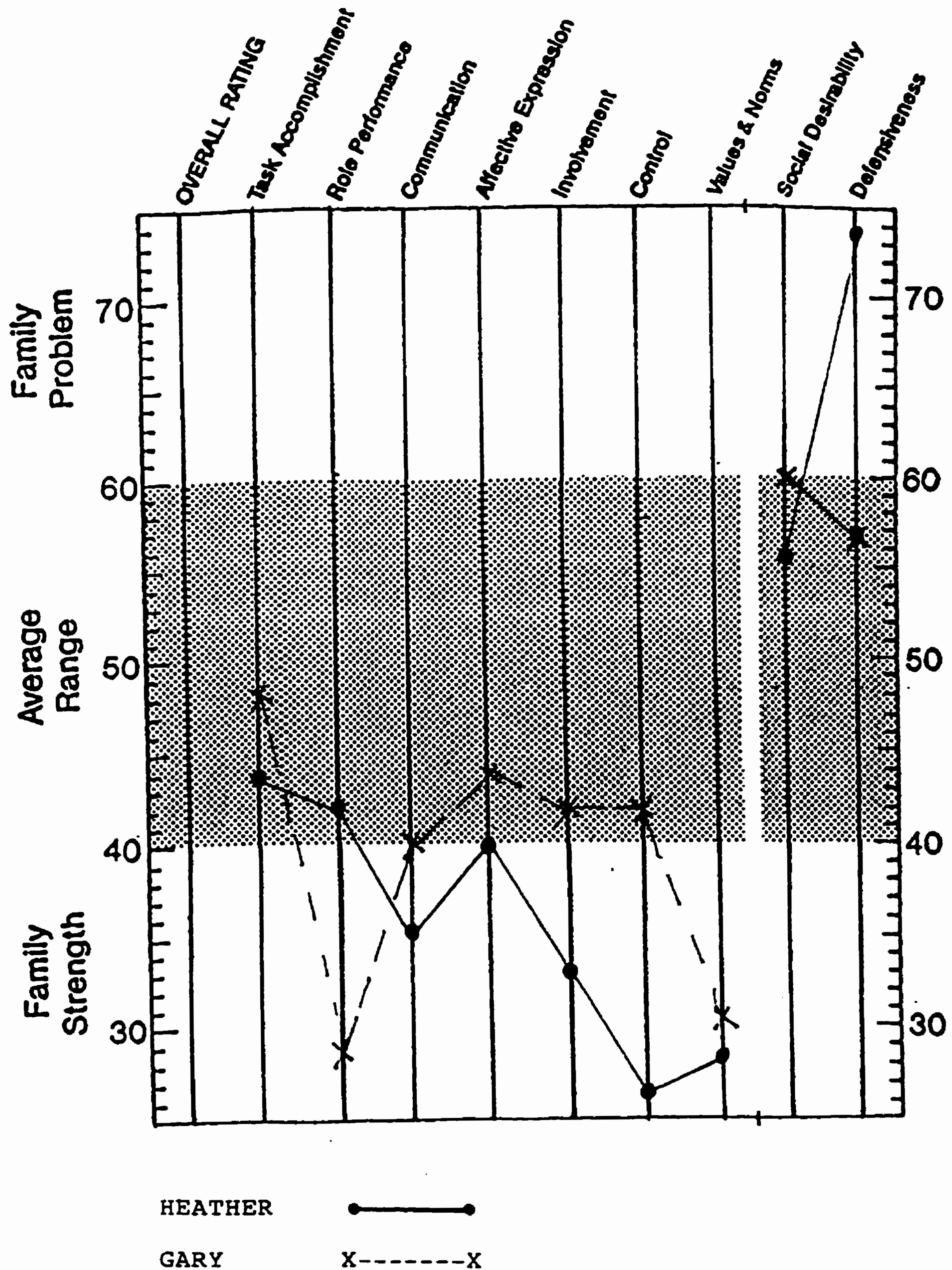
three year old. We also discussed the framework that they could use to distinguish between age appropriate sex-play versus sexually abusive behaviours.

Throughout the three sessions, I complimented Heather and Gary on how they created a safe and nurturing environment for Cole to help him process the traumatic event. Their ability to function and care for each other was highly commendable in light of the trauma they had all experienced. Heather and Gary completed a self-anchored rating scale on Cole's problematic behaviours i.e. nightmares, being fearful and upset of things going wrong. The 'anxiety self-anchored rating scale' is also included in this appendix.

At the end of our third and last session, Heather and Gary reported that Cole's behaviours had progressed tremendously at home. He was less anxious, able to sleep through the night, and was no longer afraid to use the toilet.

The outcome results of the measurement instruments are included with this Appendix. Their elevated scores on 'social desirability' and 'defensiveness' subscales indicate anxiety and potential inflation of scores on the FAM111 subscales. Therefore, caution needs to be exercised in interpreting their scores.

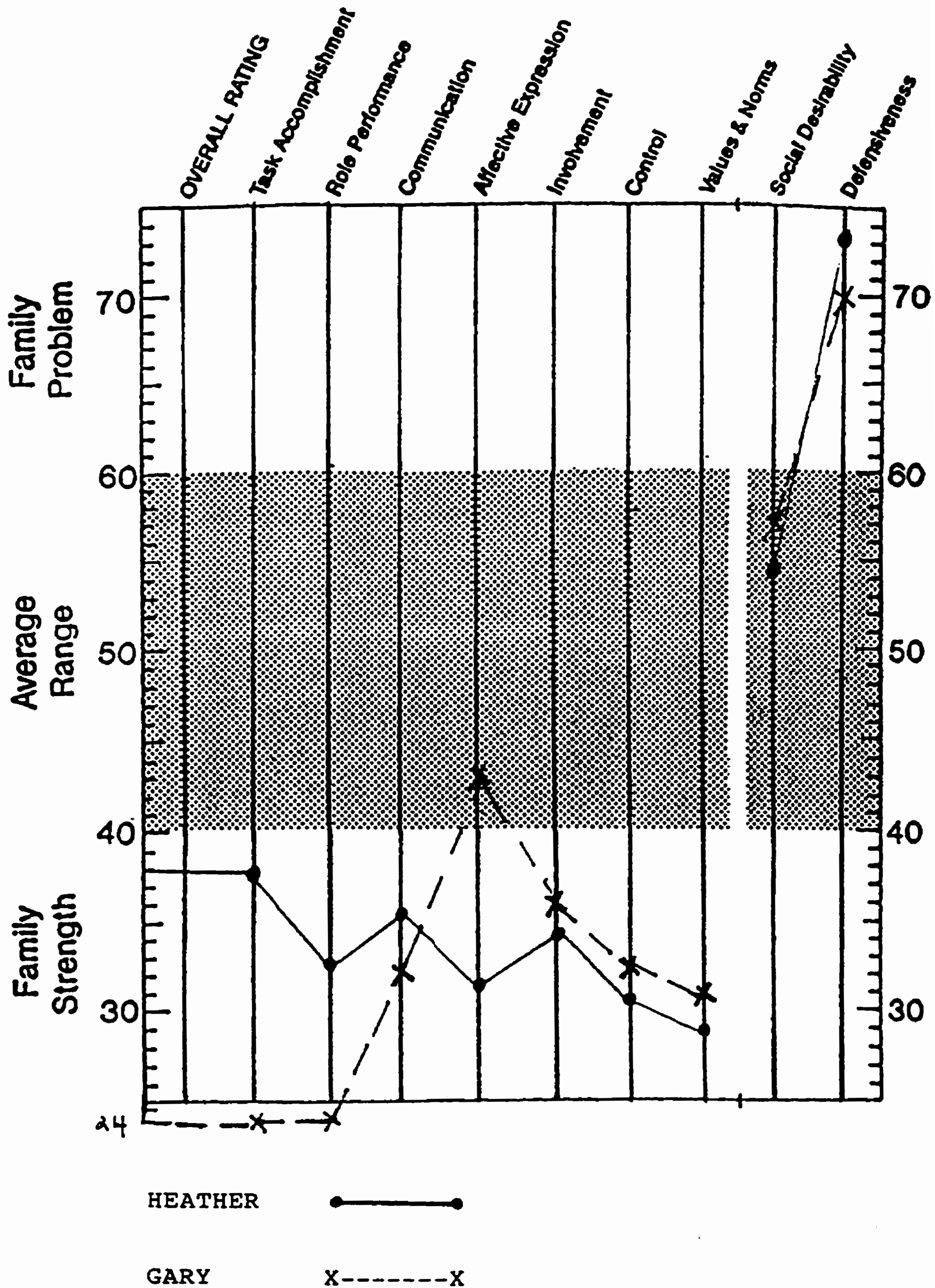
FAMILY 'P' PRE-TEST FAM111 PROFILE



HEATHER ●———●

GARY X-------X

FAMILY 'P' POST-TEST FAM111 PROFILE



Problem Checklist: Heather - Family "P" - Pre-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

	Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					X
2. Sharing feelings like anger, sadness, hurt, etc.				X	
3. Sharing problems with the family					X
4. Making sensible rules					X
5. Being able to discuss what is right and wrong					X
6. Sharing of responsibilities					X
7. Handling anger and frustration			X		
8. Dealing with matters concerning sex					X
9. Proper use of alcohol, drugs					X
10. Use of discipline					X
11. Use of physical force					
12. The amount of independence you have in the family					X
13. Making contact with friends, relatives, church, etc.				X	
14. Relationship between parents					X
15. Relationship between children					X
16. Relationship between parents and children					X
17. Time family members spend together				X	
18. Situation at work or school				X	
19. Family finances				X	
20. Housing situation					X

21. Overall satisfaction with my family					X

Make the last rating for yourself:

22. Feeling good about myself					X

NAME: Heather Date: January 22/1997

Problem Checklist: Gary - Family "P" - Pre-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)					X
2.	Sharing feelings like anger, sadness, hurt, etc.				X	
3.	Sharing problems with the family					X
4.	Making sensible rules					X
5.	Being able to discuss what is right and wrong					X
6.	Sharing of responsibilities					X
7.	Handling anger and frustration					X
8.	Dealing with matters concerning sex				X	
9.	Proper use of alcohol, drugs				X	
10.	Use of discipline					X
11.	Use of physical force					X
12.	The amount of independence you have in the family					X
13.	Making contact with friends, relatives, church, etc.					X
14.	Relationship between parents					X
15.	Relationship between children					X
16.	Relationship between parents and children					X
17.	Time family members spend together					X
18.	Situation at work or school				X	
19.	Family finances			X		
20.	Housing situation				X	

21.	Overall satisfaction with my family					X

Make the last rating for yourself:

22.	Feeling good about myself				X	

NAME: Gary Date: January 22/1997

Problem Checklist: Heather - Family "P" - Post-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)					X
2.	Sharing feelings like anger, sadness, hurt, etc.					X
3.	Sharing problems with the family					X
4.	Making sensible rules					X
5.	Being able to discuss what is right and wrong					X
6.	Sharing of responsibilities				X	
7.	Handling anger and frustration					X
8.	Dealing with matters concerning sex					X
9.	Proper use of alcohol, drugs					X
10.	Use of discipline				X	
11.	Use of physical force					X
12.	The amount of independence you have in the family					X
13.	Making contact with friends, relatives, church, etc.					X
14.	Relationship between parents					X
15.	Relationship between children					X
16.	Relationship between parents and children					X
17.	Time family members spend together				X	
18.	Situation at work or school					X
19.	Family finances			X		
20.	Housing situation					X

21.	Overall satisfaction with my family					X

Make the last rating for yourself:

22.	Feeling good about myself				X	

NAME: Heather Date: April 23/1997

Problem Checklist: Gary - Family "P" - Post-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)					X
2.	Sharing feelings like anger, sadness, hurt, etc.				X	
3.	Sharing problems with the family					X
4.	Making sensible rules					X
5.	Being able to discuss what is right and wrong					X
6.	Sharing of responsibilities					X
7.	Handling anger and frustration					X
8.	Dealing with matters concerning sex				X	
9.	Proper use of alcohol, drugs					X
10.	Use of discipline					X
11.	Use of physical force					X
12.	The amount of independence you have in the family					X
13.	Making contact with friends, relatives, church, etc.					X
14.	Relationship between parents					X
15.	Relationship between children					X
16.	Relationship between parents and children					X
17.	Time family members spend together					X
18.	Situation at work or school				X	
19.	Family finances				X	
20.	Housing situation					X

21.	Overall satisfaction with my family					X

Make the last rating for yourself:

22.	Feeling good about myself				X	

NAME: Gary Date: April 23/1997

ANXIETY RATING SCALE

Please place a check mark in the appropriate place.

As a result of therapy, were they:

		BETTER	UNCHANGED	WORSE
1.	Nightmares	✓		
2.	Being fearful and upset of things going wrong	✓		
3.	Afraid to use the toilet	✓		

Other comments:

"I'm not quite certain that these changes occurred directly because of therapy. I think they have improved because of time and love. The therapy helped me focus more on my son, then on the legal system, which in turn has certainly benefitted my son. The therapy was a definite help."

Heather

APPENDIX: S

FAMILY SIX

Family 'Q'

Family 'Q' was a single parent family consisting of the natural mother, Michelle, age 25, and her three children, Paul, age 7, Annie, age 6, and Bonnie, age 2. Michelle had chosen home schooling for her children.

This case was a self-referral by the natural mother. She was concerned about Paul because he often fought with his siblings and had an anger management problem, and she reported that he would respond with temper tantrums and 'hissy fits'. Michelle was also frightened that the next time Paul became angry and 'rebellious', she was going to 'hurt him physically'.

The family was seen for a total of six sessions. During my involvement with the family, parenting issues, coping mechanisms and how growing up in a dysfunctional home-life had impacted on her current relationship with her children. The goals for therapy changed from session to session. However, I will briefly outline the areas on which we focused the most in therapy sessions.

As therapy progressed, it became clear that Michelle was excessively tied to her children, especially Paul. As a result, emotional boundaries needed to be clarified. Throughout therapy, I emphasized that clear, emotional boundaries enabled parents to experience themselves separate from their children. She needed to realize that her children did not think and feel as she did. Assuming her own

individuality and allowing her children theirs was respectful and healthy, although not always easy to do.

I was attempting to have Michelle connect her current behaviours with her past trauma, thus giving her some context in which to understand her anxious concern about Paul's fighting with his siblings.

Michelle was also struggling with parenting issues. She wanted to find a way to set limits for her children without being to authoritarian. She was confused about how to maintain a reasonable balance between discipline and affection. There was a blind spot around authority and responsibility. She often wondered if she was being emotionally destructive with her children when she yelled at them. History was a key factor for Michelle. She was determined to prevent the repetition of her negative experiences with her children. A number of sessions focused on discussing her struggles and uncertainties about parenting and how her 'dysfunctional home life' often got in the way of setting appropriate limits with her children. I also attempted to remind Michelle that we can learn from the past, but in order to move on, history must be placed in proper perspective.

In our last session, Michelle attempted to convince herself and I that Paul's aggression towards his siblings were abusive. Perhaps he needed to be seen individually by a therapist who would teach him to behave more responsibly towards his siblings, insisting that there was nothing she

could do to help modify his behaviour. I attempted to differentiate between abusive and non-abusive behaviours in a child and cautioned Michelle not to magnify his behaviours. Also, I began to discuss with Michelle her parenting style and how she needed to modify her own behaviours in order to have Paul behave differently. It seemed that at this time, Michelle was not willing to look at the contextual aspects of her son's behaviour as a more workable solution for bringing about change.

According to Minuchin and Fishman (1981) "...therapists are frequently satisfied that a message has been recognized just because it has been sent. But a therapeutic message must be 'recognized' by family members, meaning that it needs to be received in such a way that it encourages them to experience things in a new way. Therapists must learn to go beyond the truth of an interpretation to its effectiveness" (p. 117). Throughout the sessions, I often validated and supported Michelle for the wonderful job she was doing with her children. I also acknowledged her difficulties and validated her strengths. Michelle was very resourceful in accessing services for her family. She was attending a parenting class once a week through Child and Family Services. She also contacted the Acute Treatment and Consultation team prior to family therapy. She did not find these resources to be very helpful.

This family was a struggle for me. I found myself to be very anxious and stuck because Michelle was not able to agree

on mutual goals. The goals changed from session to session.

Each time Michelle discussed issues that I did not prepare for prior to our sessions, I became so anxious that I could not direct the process. I was not yet secure enough about my ability to deal with 'unexpected' or 'unpredictable' therapeutic events.

Michelle terminated therapy by not returning for further family sessions. The case was closed and the therapeutic contract was terminated by letter. As this family did not complete the post-test measurement instruments, only the pre-test of the FAM111 profile and the problem checklist are included in this appendix.

FAMILY 'Q' PRE-TEST FAM111 PROFILE

FAM GENERAL SCALE

OVERALL RATING | Task Accomplishment | Role Performance | Communication | Affective Expression | Involvement | Control | Values & Norms | Social Desirability | Defensiveness

Family Problem

Average Range

Family Strength

70

60

50

40

30

MICHELLE

Problem Checklist: Michelle - Family "Q" - Pre-Test

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

		Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1.	Showing good feelings (joy, happiness, pleasure, etc.)		X			
2.	Sharing feelings like anger, sadness, hurt, etc.			X		
3.	Sharing problems with the family				X	
4.	Making sensible rules		X			
5.	Being able to discuss what is right and wrong			X		
6.	Sharing of responsibilities				X	
7.	Handling anger and frustration	X				
8.	Dealing with matters concerning sex					X
9.	Proper use of alcohol, drugs					X
10.	Use of discipline		X			
11.	Use of physical force			X		
12.	The amount of independence you have in the family					X
13.	Making contact with friends, relatives, church, etc.		X			
14.	Relationship between parents	X				
15.	Relationship between children			X	X	
16.	Relationship between parents and children		X			
17.	Time family members spend together	X				
18.	Situation at work or school				X	
19.	Family finances		X			
20.	Housing situation	X				

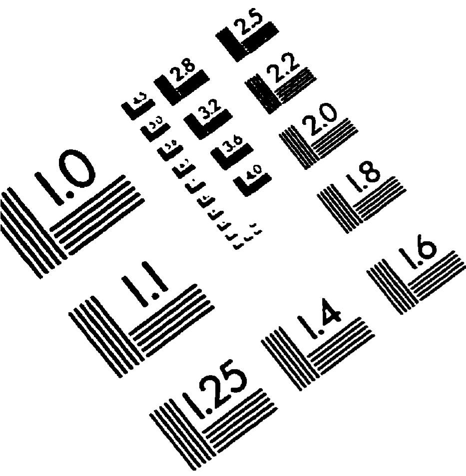
21.	Overall satisfaction with my family					X

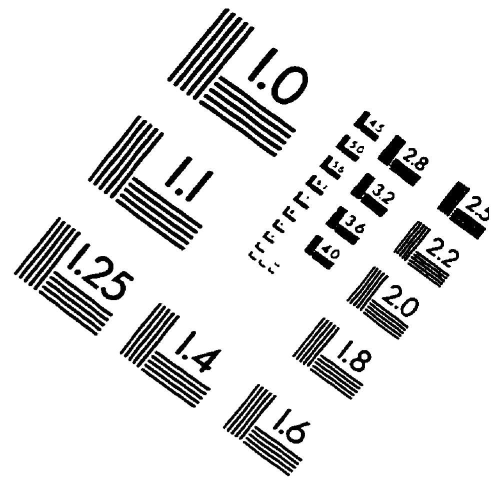
Make the last rating for yourself:

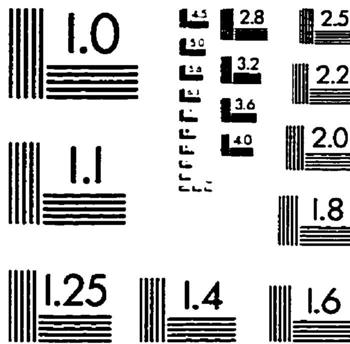
22.	Feeling good about myself				X	

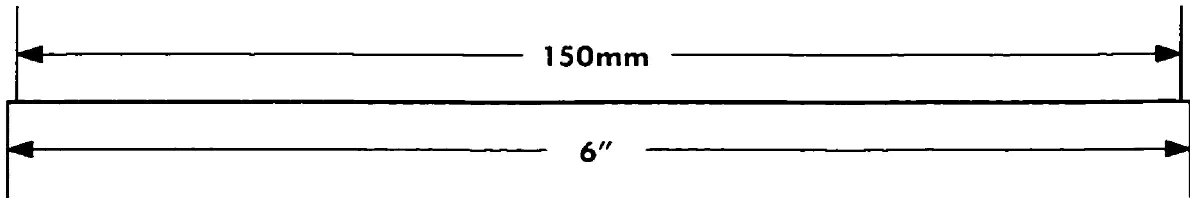
NAME: Michelle Date: February 2/1997

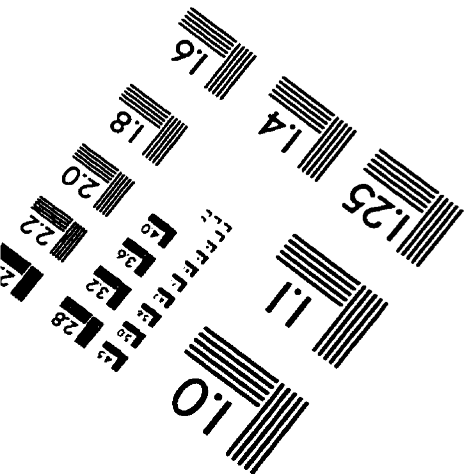
IMAGE EVALUATION TEST TARGET (QA-3)

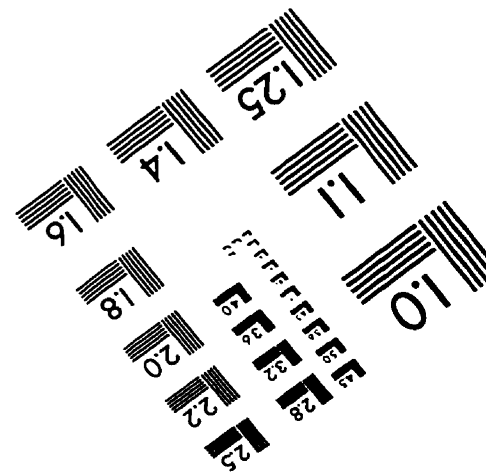












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1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

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