FAMILY REUNIFICATION: AN INTEGRATED APPROACH

by

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MASTER OF SOCIAL WORK

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GAIL M. BECKETT

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

MASTER of SOCIAL WORK

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TABLE OF CONTENTS

page

Preface

Abstract iv
Acknowledgments v
List of Tables vi

Introduction

Introduction vii
Educational Benefits To The Student viii

Chapter One-Literature Review

Introduction 1
Family Reunification 1
Solution-Focused Therapy 7
Reflection Team 19
Structural Family Therapy 25
Overall Summary 32

Chapter Two-Intervention Methods and Evaluation Procedures

Setting 34
Clients 34
Procedures 35
Personnel 37
Duration 38
Recording 39
Evaluation Procedures 39

TABLE OF CONTENTS (continued)

page

Chapter Three-Evaluation

Criteria For Evaluation 41
Evaluation Instruments
The Family Assessment Measure 42
Child's Attitude Towards Mother (CAM) Scale 45
The Family Assessment Form 49
The Family Intervention Scale 52
Case Related Information 54

Chapter Four-Case Examples and Results

Introduction 56
Results of the Evaluation 57
Case Examples
Introduction 62
Case Example A 63
Case Example B 77
Case Example C 92

Chapter Five-Implications and Recommendations 105

Chapter Six-Conclusions

Evaluation of Skill Development as a Therapist 109
Conclusions 110

References 113

TABLE OF CONTENTS (continued)

page

Appendices

Appendix A 120
FAM-III: General Scale

Appendix B 121
Child's Attitude Toward Mother (CAM)

Appendix C 122
Family Interactions Sub-Scale

Appendix D 123
Family Interventions Scale

Appendix E 124
Family Biographies
Family D 125
Family E 127
Family F 128
Family G 129
Family H 131

Abstract

This Practicum paper gives a description of a Reunification Project that attempted to reconnect children in out-of-home care with their families. This was achieved by applying a structurally based solution-focused service delivery package, in addition to utilizing a reflection team. The report reviews the conceptual approaches utilized in this project, including an overall summary integrating the models employed.

This model of practice is evaluated through the use a pre- and posttest design using various standardized measures. The Family Assessment Measure was completed by all the parents involved in the Practicum. The Child's Attitude Towards Mother Scale was completed by the adolescents. Lastly, the Family Interactions Sub-scale and the Family Intervention Scale were filled out by the Child and Family Services workers. The results of the evaluation instruments are mixed. Three case examples are provided to illustrate the use of the model, and discuss the results of the evaluation.

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I would sincerely like to thank the members of my Practicum Committee, Sara Axelrod, and Linda Campbell for their feedback and support. I would also like to thank Dr. Don Fuchs, for his guidance and insights in making this Practicum a success.

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List of Tables

Table 4.1 Case Example A 73

Table 4.2 Case Example B 88

Table 4.3 Case Example C 102

Introduction

Families are the cornerstone of society and in most cases it is best for children to live with their natural families. However, some parents cannot care for their children. In these instances the Child and Family Services worker must constantly balance the goal of family preservation with the mandate of ensuring the safety of the children.

The main purpose of this Practicum was to participate as the primary therapist for a select number of families within the Reunification Project run at The Family Centre of Winnipeg. This project attempted to reconnect children in out-of-home care with their families, by applying a structurally based solution-focused service delivery package, in addition to utilizing a reflection team. The secondary purpose of this Practicum was to evaluate the progress of the eight families chosen for this Practicum. Lastly, the purpose of this Practicum was to participate, and provide clinical case consultations at team meetings for the project, including being a member of several reflection teams for the other primary therapists who worked with families.

EDUCATIONAL BENEFITS TO THE STUDENT

The personal learning objectives of this Practicum were the following;

- To further develop and enhance assessment skills from a structural framework
- To further develop interviewing and intervention skills in solution-focused therapy
- To develop my skill level in effective evaluation procedures and data interpretation
- To increase my knowledge and effectiveness as a family therapist by working with a clinical team of professionals
- To become a more effective collaborator with caseworkers
- To examine and elaborate on any pertinent observations made throughout my Practicum work

Successful family reunification, requires a collaboration of resources which is supported by well-grounded theory that targets and responds to the needs of children and their families (Warsh et al., 1994). The Family Reunification Program is in its second year of being run as a joint partnership between The Family Centre of Winnipeg and Winnipeg Child and Family Services-East Region. This program provides service to 40 families each year, enabling children who are in alternative care to return successfully to their families. At the same time, this program recognizes that not every parent can be a daily caregiver and that the goal for these families is to strengthen family bonds.

This Practicum examined the reunification of families with children in out-of-home care from both structural, and solution-focused frameworks. An assessment model based on Minuchin's (1974) structural family therapy was employed in order to provide a map of how the family functioned. A solution-focused intervention strategy as developed by de Shazer and the Milwaukee Brief Family Treatment Centre (de Shazer, 1988) was employed to highlight and enhance behaviors that lead to solutions regarding the presenting issues. There is a mixed reaction in the field as to whether the two approaches should be integrated or not (Fish & Piercy, 1987). However, theoreticians agree that at the very minimum, any attempts to integrate the two must include a clear understanding of the assumptions and the conceptual basis of each approach (de Shazer, 1984; Sluzki, 1983; Stanton, 1981).

Sluzki (1983) suggested that the advantage to utilizing more than one model is that:

> ... the same paradigmatic frame does not reduce the requirement that conceptual consistency within models should be maintained. By means of defining their common systemic base, however, it vastly expands the repertoire of conceptual and technical tools of the family researcher, trainer, and therapist, as it empowers them with the choice within a wide range of mutually potentiating family variables, hypotheses, and interventions. (p. 475)

This Practicum is divided into several components. After this introductory section, chapter one of this report will review the literature on the four conceptual approaches utilized in this model, including an overall summary integrating the models employed. The second chapter examines the intervention methods and evaluation procedures employed in this Practicum. Chapter three explores the criteria for evaluation, as well as the evaluation instruments used in this Practicum. In chapter four the results of the evaluation measures will be analyzed, including an in-depth examination of the model applied to three case examples. Chapter five consists of the conclusions and recommendations drawn from this Practicum experience.

Chapter One

Literature Review

INTRODUCTION

The literature review of this report will be divided into four sections. The first will review the literature concerning family reunification. The second section will review the conceptual assumptions of solution-focused therapy. Followed by a review of the relevant literature on reflecting team formats. The fourth section of this report will explore the conceptual assumptions of structural therapy as an intervention model. A summary and comments section will follow each of the above sections. Lastly, an overall summary will integrate the conceptual models utilized in this Practicum.

FAMILY REUNIFICATION

A renewed emphasis in child welfare has focused attention on the goal of family reunification. Family reunification as defined by Maluccio et al. (1993) states that:

> Family reunification is the planned process of reconnecting children in out-of-home care with their families by means of a variety of services and supports to the children, their families, and their foster parents or other service providers. It aims to help each child and

family achieve and maintain, at any given time, their optimal level of reconnection from full reentry of the child into the family system to other forms of contact, such as visiting, that affirm the child's' membership in the family. (p. 6)

This definition underscores the value of maintaining and enhancing connectedness or reconnectedness between children in out-of-home care and their families. At the same time, it recognizes that not every parent can be the primary caregiver and that some families, though not able to live together, can still maintain kinship bonds (Maluccio et al., 1993). The terms parents and families are used in a generic sense and refer to those parents or caregivers who are meaningful to the child and with whom family reunification is being considered. While for the most part this refers to biological parents or families, reconnections can also include adoptive parents, grandparents, foster parents, or other significant attachment figures the child may have (Warsh et al., 1994).

Reunification practice is guided by a family-oriented, competence-centered perspective that emphasizes promoting family empowerment, to enhance family functioning. To accomplish this, the process centers around helping parents to learn new behaviors, emotional responses, and skills and values needed to function and fulfill their parental roles in a more satisfying and successful manner. This approach also emphasizes identifying and mobilizing the strengths and potentials of children and other family

members in order to promote family empowerment (Carlo & Shennum, 1989; Warsh et al., 1994).

Zamosky et al. (1993) state how an underlying belief in the potential of all families to care adequately for their children, coupled with a "strength" focus, is uniquely suited to reunification efforts:

> Several beliefs guide the strengths approach: empowerment of individuals and families is necessary for people to manage their own lives; families have strengths, can change, and can take charge of their lives despite difficult past or present circumstances; families should be full partners in a collaborative effort with helpers to achieve mutually established goals; and the family's extended social network and all involved helpers must be included in the process. (p. 156)

A strengths perspective assumes that the family has all it needs to solve its own problems. This is true even when families desperately struggle to survive or when obvious deficits exist within families. Believing that the family has strengths, which in turn become the solutions to problems does not mean that additional help cannot be provided or that others may not provide new information to assist the family. When the emphasis is on unlocking and amplifying the family's own assets, however, the result is a solution unique to the family, one that the family owns, and one that is likely to last (Zamosky et al., 1993). Although treatment

interventions may not be able to reconstruct a family back to an ideal image, they can ameliorate family dysfunction and help them to live together as successfully as possible (Carlo & Shennum, 1989).

Work done by Warsh et al. (1994) suggests that some of the underlying principles and guidelines involved in family reunification include the following:

> As a form of preserving families, reunification embodies a) conviction about the role of the biological family as the preferred child-rearing unit, if at all possible; b) recognition of the potential of most families to care for their children, if properly assisted; c) awareness of the impact of separation and loss on children and parents; and d) involvement, as appropriate, of any and all members of the child's family, including members of the extended family or others who, while not legally related, are considered by the child and themselves to be "family." (p. 4)

In addition, Warsh et al. (1994) identifies human diversity (e.g., culture, race, ethnicity, and ability) as another principle for reunification practice that should be respected. Life-styles and child-rearing methods that might be considered different or unusual should be accepted as long as they promote a child's health and safety. This principle is especially relevant because a disproportionate number of children in care come from

low-income or minority families, whereas most practitioners are Caucasian and from middle-class family backgrounds.

Visiting between the child and family is an essential ingredient in preparing for and maintaining a successful reunification. Child-family interaction can serve as a laboratory in which both parties work on the problems that may have contributed to the need for placement and learn new ways to be together again (Warsh et al., 1994).

Collaboration is particularly important in family reunification work due to the variety of professionals who are frequently involved with families. Collaboration among professionals and family members can decrease tension among providers, increase conflict resolution and group consensus, improve coordination and delivery of services to children and families, and create a cooperative environment in which plans for reunification can be successfully generated, implemented and maintained (Werrbach, 1993).

Although a substantial proportion of children in placement could be successfully reunified with their families, the reality is that in many cases the plan for reunification is not always in the best interests of the child. Therefore, the most appropriate or optimal level of reconnection should be identified and pursued. Sometimes family connection without cohabitation (e.g., visits, telephone or written communication) is the best case resolution, as suggested by Maluccio et al. (1993). Other times, the

attempt to reunify, is the last, best attempt at reasonable efforts to enable termination of parental rights to take place as a prelude to whatever permanent plan is appropriate for the child (Fein & Staff, 1993). The resulting out-of-home placement may not be a negative life course outcome for children but may, in fact, represent the best arrangement for a particular child at that particular moment in his or her life (Walton et al., 1993).

Summary and Comments

In summary then, the "challenge is for family reunification to cease to exist-the ultimate goal of child welfare services" (Hartman, 1993, p. xxi). With adequate resources and proper planning family reunification would no longer be required. The focus instead would be on how to maintain and preserve families. There would be no "re" in front of "unification" and "connection." In this imperfect world, however, it is necessary to give special attention to family reunification and reconnection approaches (Hartman, 1993).

An underlying belief in the potential of all families to care for their children, combined with a "strength" focus, is uniquely suited to reunification efforts. "A strengths approach embraces the idea that all families have both strengths and problems, and that the strengths are the keys to solutions to problems" (Zamosky et al., 1993). These beliefs are

consonant with a number of empowering approaches, such as solution-focused therapy.

Hess and Folaron (1991) however, state that, deeply felt or consistent ambivalence about parenting, can contribute to serious difficulties in fulfilling the parent role. Whatever degree of ambivalence about parenting that existed, those feelings and behaviors are likely to be heightened as placement continues, particularly if parents observe that their child(ren) are better cared for by temporary caregivers.

Lastly, even reunified families must cope with the multiple challenges of single-parent households, the needs of children who exhibit multi-behavioral problems, and the difficulties associated with out-of -home placements. Poverty, homelessness, unemployment, substance abuse, and the effects of child abuse and neglect are also obstacles that must be addressed when reunification is considered (Maluccio et al., 1994).

SOLUTION-FOCUSED THERAPY

Traditionally therapy was oriented primarily to the past, searching in the client's childhood for the underlying cause of present problems. Now there is an emerging trend to focusing on strengths, capabilities, and resources in therapy rather than focusing on pathology and deficits. There is also a move away from searching for the roots of the person's difficulties, to looking for solutions that will be effective for the particular

individual, couple or family seeking help. This solution orientation challenges many traditionally held beliefs.

Among the forerunners of this new approach the most influential were Milton Erickson, the Mental Research Institute's Brief Therapy Clinic (hereafter referred to as MRI), and Steve de Shazer and his colleagues at the Milwaukee Brief Family Therapy Center (or BFTC).

O'Hanlon and Weiner-Davis (1989) state that Milton Erickson viewed clients as having the resources within them or within their social systems to make the necessary changes, and that the therapists job is to access these resources and help clients put them to appropriate use. Minuchin and Fishman (1981) state that:

> In Milton Erickson's work with individuals, he addressed himself consistently to the "fact" that individuals have a reservoir of wisdom learned and forgotten but still available. He suggested that his patients explore alternative ways of organizing their experience without exploring the etiology or dynamics of dysfunction.... One strategy is therefore to bypass an exploration of the historical underpinnings of dysfunctional transactions and to take a shortcut of exploring other, more complex modes of transacting that promise healthier functioning.... (p. 268-269)

Erickson didn't view people as being fundamentally flawed. He also believed therapy could be accomplished very quickly as problems don't

need to be explored in detail or defined exactly. He emphasized the role of positive expectations in bringing about change. In addition, Erickson's questioning of resistance contributed to the development of the concept of cooperation (O'Hanlon & Weiner-Davis, 1989). Clients' noncompliance is viewed as their way of educating the therapist as to the methods that will be the most helpful.

Erickson developed a technique (later called by de Shazer the "crystal ball technique") using hypnosis to help people create a sense of time distortion, so that they could readily go back and forth in time. He called this "pseudo-orientation in time" (Rossi, 1980). Once clients were adept at time distortion, he helped them form the skill of amnesia. Following which he would direct them to a time in the future, after their problem was solved, and asked them to hallucinate an encounter with him in this imagined future in which they told how they solved their difficulty. After they had described the scene to him, he had them develop amnesia for the experience and sent them on their way. Later on clients usually reported having resolved their difficulties (O'Hanlon & Weiner-Davis, 1989).

Erickson was not completely solution-focused, nor was his approach always brief. Nevertheless, his work inspired much of solution-oriented therapy.

In 1966, the MRI therapists began working to try to resolve clients'

presenting problems rather than to reorganize families or develop insight. Many of the principles of the MRI brief therapy model can be considered precursors of solution-oriented therapy.

O'Hanlon and Weiner-Davis (1989) state that within this model there was no attempt to search for the underlying cause of the problem. Problems were seen as developing out of ordinary life difficulties being mishandled. Once the difficulty is viewed as a "problem," the problem is maintained or worsened by people's unsuccessful attempts at resolving that issue. Thus, the problem is the "more of the same" pattern which ensues. The therapeutic intervention within this model focuses on clients receiving some variation of the suggestion that they stop trying to solve the difficulty in the way that they have been attempting. Often this is accomplished by "reframing" the client's belief system by placing it in another frame which fits the same situation equally well or even better, thus changing the entire meaning. As clients begin to view things in a new way, they can begin to respond differently.

The BFTC team departed from the problem-solving, problem-focused approach from which this model emerged to an emphasis on solutions and how they worked. Notably, Steve de Shazer, Insoo Kim Berg and their colleagues from the Milwaukee team developed an approach which is less problem focused and more solution-oriented (de Shazer, 1985). The model of therapy developed at BFTC is called solution-focused brief therapy.

The following assumptions seem to be common to solution-focused therapy:

1) Clients are the experts about their problems and lives and have the resources and strengths to resolve their complaints.

2) It is usually unnecessary to know a great deal about the complaint in order to resolve it.

3) It is not necessary to know the cause or function of a complaint in order to resolve it.

4) Cooperation is necessary and mandatory. The notion of resistance does not exist.

5) A small change is all that is necessary; a change in one part of the system can affect change in another part of the system.

6) Rapid change or resolution of problems is possible.

7)There are many ways of looking at a situation, none more correct than others.

8) Clients define their own goals, but they can also be co-defined with the therapist.

9) Change is constant and inevitable.

10) It is easier to build on success than it is to stop an undesirable behavior.

11) The therapists' job is to identify and amplify change.

Basic to this approach is the concept of co-creation of solutions by

client and therapist. This is based on the respectful assumption that clients have inner resources to construct highly individualized and uniquely effective solutions to the problems that bring them to therapy. Solution-focused therapists ask questions in therapy which are meant to elicit information about strengths, abilities, and resources. Clients' problems and how they are viewed change significantly through this kind of questioning. The therapist's focus when using a solution-focused approach is on talking about change, searching for differences that make a difference, and solutions rather than talking about difficulties, complaints and problems (Lipchik & de Shazer, 1986).

de Shazer (1988) states that various types of therapist-client relationships develop that can be categorized as falling into one of three groups. The general term "client" can be applied to "visitors," "complainants," and "customers" alike.

"Visitors" are either people who seem to have no complaints and their reason for seeking therapy is simply that someone told them to come, or they can believe there is a problem but they do not think anyone can solve it. Thus, therapy cannot begin and therefore it is a mistake for the therapist to intervene regardless of how obvious the "problem" may be to an observer. With this type of clientele, any intervention is likely to be rejected and, thus, the therapist's error in not recognizing these people as visitors sets up a classic "resistant relationship" between them. In these

situations therapists find it useful to give lots of compliments but no task at the end of the first session.

"Complainants" are those people who are very observant and can provide a detailed description of complaints. By the end of the assessment phase, it is clear that the therapist and the client have the beginnings of a goal and some expectation of change and possible solutions. The client, however, is either not committed to taking the necessary steps to resolve the problem or is not clear that he/she must take steps to find solutions. As with the "visitor" type relationship, the therapist should provide lots of positive feedback about what the client is doing right. In addition, an observational task can be given which is intended to build on pre-existing solutions or strengths.

"Customers" are distinguished from other complainants solely because of how the customer describes his situation and his goals. By the end of the assessment phase, the therapist and client together have constructed a complaint, which includes at least the beginning of a goal and some expectations of a solution. Additionally, the client is aware that any solution requires his taking action, and there is some expression either verbally or non-verbally of willingness to do something to find the necessary solutions. Again the therapist should provide lots of positive feedback about what the client is doing right. The therapist should also agree that the client is right about needing to do something to resolve the

problem. In these situations, the therapist can give behavioral tasks with a high degree of confidence that the customer will follow through with the task and find it useful.

During a series of sessions these relationships change and develop. Visitors can become complainants, and complainants can become customers, while customers can become complainants. For this reason, at any given time a therapist-client relationship may not fall into a "neat" category, requiring that the therapist take a conservative approach rather than overestimate the type of relationship.

A framework for a whole series of questions (known collectively as "the miracle question") is used during the first session to help both the client and therapist describe what a solution would look like even when the problem is vague, or poorly described. Developed by de Shazer, the "miracle question" was adapted from Erickson's "pseudo-orientation in time"/ crystal ball technique described earlier. Although work with the crystal balls was done using formal hypnosis, solution-focused therapy is done without any formal hypnosis (de Shazer, 1988). The basic miracle question is: "Suppose that one night, while you were asleep, there was a miracle and this problem was solved, How would you know? What would be different" (de Shazer, 1988, p. 5). Having a client contemplate this question helps to build the expectation that the problem will be solved and then this expectation, once formed, can assist the client towards creating a

self-fulfilling prophecy. Also, it gives the therapist guidelines and concrete information as to how to assist the client achieve their goals (O'Hanlon & Weiner-Davis, 1989).

The BFTC team also developed the "exception question" which directs the client to search in the present and the past rather than to the future for solutions by focusing on those times when the client did not experience their problem. The goal of the first interview is to direct the client's thinking away from the negative complaints and toward an answer to the question "What's different about the times when this problem doesn't occur?". By amplifying their descriptions of these times, clients may discover solutions that they had forgotten about or that they deemed insignificant (O'Hanlon & Weiner-Davis, 1989). "For the clients, these are not differences that make a difference; making these differences make a difference is the heart of the therapist's job" (de Shazer & Berg, 1988, p. 42).

Whether an interview has produced an exception to the difficulty or not, goals have to be set in order to provide direction and a means for evaluating the outcome. "Without this step, therapy could reasonably go on forever" (de Shazer, 1988, p. 93). Ideally, "the goal is a small piece of the solution expressed in the most specific behavioural terms possible in order to serve as a useful guidepost toward solution" (Lipchik & de Shazer, 1986, p. 94). Even in situations where the problem is so vague that even

the therapist cannot report what the client is complaining about effective therapy can still be accomplished (de Shazer, 1988). Since the focus is on solutions one only needs to know how the client will know when the issue is solved (de Shazer et al., 1986).

When no exception is discovered, and the development of specific goals has been unsuccessful, the therapist continues to react in a cooperative manner by maintaining rapport and "promoting fit". The concept of fit deals with the relationship between the therapist and the client(s), and involves the establishment of a rapport which involves feelings of closeness and responsiveness (de Shazer, 1988). When fit is established, all the participants pay close attention to what the others are saying. Fit can be said to include, "the therapist behaving in such a way that it is clear to his client that he (the client) has everything needed to solve the problem" (de Shazer, 1988, p. 91).

The purpose of later sessions is to assess whether or not the previous session and its intervention has made any difference toward the resolution of the problem. If it has, and some change is reported by clients, the therapist's task is to build on these changes. It not, the therapist continues to develop and promote fit (Lipchik & de Shazer, 1986).

Summary and Comments

O'Hanlon & Weiner-Davis (1989) state that in solution-focused

therapy, therapists are trying to do three things: 1) change the "doing" of the situation that is perceived as problematic; the goal is to change actions and interactions so that the client can resolve their situation rather than repeat unsuccessful patterns: 2) change the "viewing" of the situation that is perceived as problematic; changing clients' frame of reference can lead to changes in action and stimulation of unused potentials and resources: 3) evoke resources, solutions and strengths to bring to the situation that is perceived as problematic; reminding and exposing people's resources, strengths and abilities can lead to changes in actions and viewpoint.

The above assumptions provide a sound and useful foundation for working with families who are wanting to reunify, as solution-focused brief therapy offers both the family and the therapist an efficient and practical means for solving problems. The notions that client and therapist can co-define goals and solutions to problems, that clients are the experts about their problems and lives and have the resources to solve their problems, and the focus on exceptions to when the problem does not exist, all grant wonderful optimism in the context of a very difficult and demanding treatment process. Many families feel stuck, powerless, damaged and problematic, and these treatment principles serve a useful purpose of highlighting contrary views of clients and their ability to overcome their problems in therapy.

One of the major issues people have with solution-focused ideas is the notion that the past is not relevant, nor does it have purpose for discussion in therapy. Thus, this approach is criticized for failing to examine the underlying cause of the problem. Sirles et al. (1993) states that solution-focused therapy emphasizes what has to happen in the present to eliminate the problem in the future, not why the problem existed in the first place. It also focuses on exceptions to the complaints, and on existing and potential strengths and solutions, rather than the details of the problem.

A common complaint regarding solution-focused therapy involves the problem that some therapists "focus exclusively on the technique and neglect the actual flesh and blood client sitting with them" (Lipchik, 1994 p.37). Lipchik (1994) explains that a therapist's unwillingness to hear the client's full expression of feelings and conditions of the problem may result in the client's belief that the therapist does not understand him or her. A consequence of this lack of understanding can result in the client's loss of confidence in the treatment process and the premature termination of therapy.

Perhaps even more detrimental is when a therapist hastily redirects the focus of discussion to the solution rather than the problem. While it is true that solution-focused therapists do not encourage the ventilation of feelings, or a detailed description of the client's past negative experiences,

therapists "must allow clients to tell their story in their own way so they can join with them and demonstrate acceptance and understanding" (Lipchik, 1994, p. 37).

REFLECTION TEAM

The reflecting team format, first developed by Tom Andersen in collaboration with team members in Norway has become a popular new way of doing therapy. Andersen first outlined reflecting teams in his 1987 article titled "The Reflecting Team: Dialogue and Meta-Dialogue in Clinical Work."

One of the main contributions to this new approach have been the writings of Gregory Bateson. Bateson (1972) raised the notion that there is not one correct history or story, and that two people will most likely make different distinctions of the same available information or different "maps" of the same "territory." In considering Bateson's statement that information "is a difference which makes a difference" (p. 453) it is important to differentiate between three kinds of difference. The first is a difference that is too small to be noticed by the recipient, meaning the exposure made no difference, in which case, if people are exposed to the usual they tend to stay the same. The second is an appreciable difference, meaning that if people are exposed to something unusual, this might induce a change. The third is a difference that is too great, meaning that the exposure is too

unusual, in which case the system may close itself to those who would try to implement such a difference. Therefore, the therapist and/or team should strive to raise questions or remarks that are new to the family, but not too unusual, which may offer a new perspective or difference, that leads to a change. This different perspective is not intended to replace the participants' story with a "better" one but possibly to add an alternative to their story. This is done through conversation with the clients, using questions and reflections in the interview. Through this process a new picture may emerge for clients (including the therapist), leading to the dissolution of an earlier view of the dilemma (Andersen, 1987; Andersen, 1991).

This format is known as the reflecting team. The French meaning of the word means: "something heard is taken in and thought about before a response is given" (Andersen, 1991, p.12). The team can be composed of the interviewer who remains with the family throughout the session plus two or three team members behind a one-way mirror. That part of the team that listens to the interview and thereafter comments on observations made throughout the session is called the reflecting team. At some point in the interview, usually after forty to sixty minutes of exchange, the conversation will reach a natural pausing point or conclusion, following which the primary therapist and the family trade places with the reflecting team so that the family can observe the reflecting team discuss their perceptions

and ideas about the interview (Andersen, 1991).

The reflecting team usually talks between five to ten minutes. They are never interrupted unless the reflections become such that those who listen cannot take it anymore, which is extremely rare (Andersen, 1991). Davidson et al. (1988) state that during the reflection, team members offer their speculations freely, providing multiple perspectives on clients' problems without a prior discussion amongst members.

Reflections follow some general guidelines. All reflections are presented in a tentative manner, using such words as "perhaps," "I wonder," "I had this idea." (Davidson et al., 1988). Comments are presented within a positive framework as opposed to a negative one, presenting a "smorgasbord of ideas" versus correct "interpretations," (Andersen, 1991). The team may also raise comments, questions and recommendations that the therapist did not or could not address during the interview, like suspected alcohol/substance abuse, incest, and/or violence (Davidson et al., 1988). In addition, the team can comment on strengths that were displayed but seemingly overlooked by clients (Andrews & Frantz, 1995).

When the team has finished their discussion, the therapist and clients switch back to their original places, and resume the interview, discussing the teams' conversation, with the team members again becoming observers (Davidson et al., 1988). The interviewer starts the discussion with an open

question, "Is there anything from what you have heard you would like to comment on, talk more about, etc.?" As the clients respond to the reflections, the therapist can see if any new pictures or meanings have developed for the family. After everyone is given the opportunity to elicit their thoughts, the interviewer might her/himself present for discussion the ideas s/he came up with while listening to the team (Andersen, 1991). Ideas or messages that they did not "hear," or are not useful at present, are still available to consider at a later date (Davidson et al., 1988).

The interviewer may have noticed during the teams' reflection that one or more family members displayed negative responses to something that was said and that this was not expressed when given an opportunity to comment on the reflection. In such instances, the interviewer might ask: "When this or that was said, I wondered if it might have been hard for people to hear or think about. But I am not sure." This may provide people with an opening to express their concerns (Andersen, 1987).

"The reflecting team has to bear in mind that its task is to create ideas even though some of those ideas may not be found interesting by the family, or may even be rejected. What is important is to realize that the family will select those ideas that fit" (Andersen, 1987, p. 421).

Summary and Comments

Most people who seek help come expecting the experts to offer

statements and judgments about them. The use of the reflecting team format creates a situation in which the therapist and the family experience themselves joined in a common enterprise, on the same team in a new and satisfying way. As this technique focuses on existing strengths and a search to maximize new possibilities, there is a pervasive feeling of curiosity and high energy. This approach enables clients to begin to develop a new story or picture of their situation and to generate new solutions which were not thought of prior to the interview. The session usually ends with participants feeling generally positive and hopeful (Andrews & Frantz, 1995).

The use of a reflecting team model offers the therapist and family numerous benefits. As clients' respond to the initial reflection, the therapist can assess if any new pictures or meanings have developed. If further therapy sessions are requested, the wide range of information presented at the initial interview can be utilized by the therapist and team to reinforce new interpretations that have emerged. Thus, the therapist is able to begin future sessions from a nonhierarchical, lateral position, respecting and empowering the family's expertise of lived experience (Andersen, 1991). In addition, the reflecting team can be particularly helpful with families suffering from serious difficulties who have appeared resistant to other therapeutic interventions (Davidson et al., 1988).

Davidson et al. (1988) state that working as a collaborative,

noncompetitive team helps avoid professional "burn-out" and enables team members to share clinical work and ideas with one another. One of the most significant benefits, however, is that clients often report feeling understood and respected right at the beginning of therapy. Consequently, therapy is viewed as a collaborative experience, rather than the therapist seen as the expert and the clients seen as "sick."

One of the drawbacks, is that because of a lack of conceptual clarity and research, reflecting teams may remain a faddish practice technique. Meaningful research may never occur on reflecting teams as long as there remains no agreement on the assumptions that comprise its theoretical base (Jenkins, 1996).

Another drawback is that when reflecting teams are used for consecutive sessions over the course of therapy the team may no longer be able to generate new ideas which are different enough to the therapist and family (Roberts et al., 1989).

Lastly, one of the ethical dilemmas generated with a reflecting team approach involves the endorsement of "not being judgmental or critical" with clients, which may put clinicians at odds with societal guidelines for handling incidents such as violence and abuse. Thus the difficulty becomes balancing the need to deal with such critical issues with the notion of "not being judgmental" (Jenkins, 1996).

STRUCTURAL FAMILY THERAPY

The structural model is based on the work of Salvador Minuchin, and is best represented in his book "Families and Family Therapy" (1974). A definition of 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 family members in that group are altered accordingly. As a result, each individual's experiences change" (Minuchin, 1974, p. 2). Thus the foundation of family therapy is based on the premise that the therapist joins the family with the goal of changing family organization in such a way that the family members' experience change.

Minuchin (1974) states that what usually brings a family into therapy is the symptoms of one member of the family, the identified patient. When a family labels one of its members "the patient", the identified patients' symptoms can be assumed to be a system-maintaining device. The symptom may be an expression of a family dysfunction, or in response to a particular life circumstance which is then supported by the family system. "In either case, the family's consensus that one member is the problem indicates that on some level the symptom is being reinforced by the system" (Minuchin, 1974, p.110). Families want the therapist to change their situation without changing their preferred transactional patterns. The identified patient,

however, is regarded by the therapist merely as the family member who is expressing, in the most visible way, a problem affecting the entire family system. Thus the whole family must be the target of therapeutic interventions in order to change the way in which family members relate to one another.

Normal families are constantly struggling with problems. What distinguishes a normal family from an abnormal one isn't the absence of problems, but a functional family structure. "The nature of these struggles changes with developmental stages and situational crises. Normal family life is neither static or problem free" (Nichols & Schwartz, 1995, p. 216).

In assessing the family's interactions, the structural model proposes the use of four essential concepts. Family structure, subsystems, boundaries, and hierarchies can all be determined in order to create a "map" of the family (Fish & Piercy, 1987).

"Family structure is the invisible set of functional demands that organizes the ways in which family members interact" (Minuchin, 1974, p. 51). Families are systems that operate through transactional patterns. When these transactions are repeated, enduring patterns are established. These repeated patterns determine how, when, and to whom family members relate (Minuchin, 1974).

Minuchin (1974) states that the transactional patterns that regulate family members' behavior are constrained by two systems. The first is

generic, pertaining to the universal rules governing family organization. For example, there must be a power hierarchy between parents and their children. In this situation authority is structured on the basis of position and age within the family. There must also be a complementarity of roles, such as a husband and wife operating as a team. The second constraining system is *idiosyncratic*, based on the mutual expectations of particular family members. These expectations develop over a period of years through implicit and explicit negotiation among family members. Frequently they often become so entrenched that their origin has been forgotten.

Thus the family system maintains itself through these preferred patterns, which are self-perpetuating and resistant to change beyond a certain range. Alternative patterns are available, but deviations that cross the system's tolerance threshold elicits mechanisms which re-establish equilibrium, for example, guilt-inducing tactics. The family structure must, however, adapt when circumstances change. Since the family must respond to internal and external changes it must be able to adapt itself to deal with the new circumstances without losing the continuity that provides a frame of reference for its members (Minuchin, 1974).

The family system carries out its functions through subsystems of members who join together to perform various functions (Minuchin, 1974). Every individual is a subsystem, and dyads or larger groups make up other subsystems, determined by generation, gender, or common interests. Every

family member plays many roles in several subgroups, each role having varying degrees of power (Nichols & Schwartz, 1995).

Minuchin (1974) states that boundaries are the invisible barriers that surround individuals and subsystems regulating the amount of contact with others, who participates, and how. "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" (p. 54). Boundaries vary along a continuum. At one extreme they can be disengaged, that is, the boundaries are inappropriately rigid and too distant. Disengaged families tend to avoid conflict, thus minimizing interaction. On the positive side, this promotes mastery, independence and growth, but it is at the expense of warmth, affection and support (Nichols, 1984). At the other end of the continuum are enmeshed boundaries which are overly diffuse and too close. Enmeshed boundaries result in blurred differentation between family members, and a heightened sense of belonging. Enmeshed subsystems offer an elevated sense of mutual support but at the expense of mastery, independence and growth. All families can be conceived of as falling somewhere along a continuum whose poles are the two extremes. Most families fall within the wide normal range. Families operating at the extremes of the continuum do indicate possible pathology. In such cases the structural therapist functions as a

boundary maker, increasing either proximity or distance between family members (Minuchin, 1974; Nichols & Schwartz, 1995).

According to Minuchin (1974) boundaries also establish the hierarchical structure within the family. Of particular importance is the boundary around the parental subsystem. A clear boundary is essential if the parents are to be in a position of authority. Parents cannot carry out their executive functions unless they have the power to do so. Effective family functioning requires that parents and children accept the fact that parental authority is a necessary component for the parental subsystem.

Minuchin (1974) also conceptualizes certain coalitions that are seen to maintain family dysfunction, or initiate the development of behavioral problems. Some of the most common types of dysfunctional coalitions described in structural family therapy include; stable coalitions, detouring coalitions, and triangulation. A stable coalition is the joining together of two family members against a third so that the pattern becomes inflexible. For example, when one parent joins with a child in a rigidly bounded cross-generational coalition against the other parent. The detouring coalition is a form of a stable coalition characterized by its intent to diffuse the stress between the members of a coalition by designating another party as the source of their problem. An example of a detouring coalition occurs when parents use a child to detour or deflect spouse conflicts. Lastly, in triangulation each of two opposing parties seeks to join with the same

person against another. An example of this would be when each parent demands that their child side with him or her against the other spouse (Aponte & VanDeusen, 1981).

Summary and Comments

The structural model provides a means for assessing family functioning, and for determining the nature of the organizational problem that produced the symptom. Fish and Piercy (1987) summarize structural therapy as:

> ... based on the theoretical assumption that families are evolving, hierarchical organizations, with rules, or transactional patterns, for interacting across and within subsystems...symptomatic behavior is maintained by an inadequate hierarchy and boundaries, and improving a family's organization will change not only the symptomatic behavior, but the individuals who are part of that organization. (p. 122)

The advantage of this model is that it stresses focusing on the family as a social system in transformation, rather than emphasizing pathology. "With this orientation, many more families who enter therapy would be seen and treated as average families in transitional situations, suffering the pains of accommodation to new circumstances" (Minuchin, 1974, p. 60).

Thus the above approach can be utilized as an effective diagnostic

tool when assessing families wanting to reunify. As it allows clinicians to streamline their interventions where it is most warranted following the initial session. In addition, due to the compatibility of the theory with a broad range of techniques, structural therapy can be easily combined with other approaches, to enhance treatment. Thus structural family therapy in combination with other empowering approaches, such as solution-focused therapy, can be a powerful treatment approach when working in the family reunification field.

Hoffman (1981) maintains, "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, especially in cases of what Minuchin would call enmeshed families" (p. 270).

Walters et al. (1988) also highlight concerns regarding the concepts of hierarchy and boundaries, which they believe is based on the male model of closeness or distance in relationships, and ignores female styles of interaction. They note that "... the concept of hierarchy often does not leave room for the female style of decision making in a more consensual or collective way, or for exerting authority (with children, for example) more through relationship than through explicit use of power" (p. 24).

Goodrich et al. (1988) note that structural therapy concepts of

hierarchy and subsystems are based on the two parent family model. Thus when assessments are made using strictly a structural approach single parent families are at distinct disadvantage.

In addition, Piercy and Sprenkle (1986) note that structural therapy does not explore behavioral patterns and interactions which occur out of session. Therefore, unless behaviors are viewed or discussed within the interview, they might not be attended to.

OVERALL SUMMARY

Clinicians have an ethical responsibility to provide effective and efficient treatment interventions to their clients. Both structural and solution-focused models have proven to be effective in clinical situations concerning families with adolescents (Fishman, 1988; Berg & Gallagher, 1989).

Structural and solution-focused approaches share many similarities. Fish & Piercy's (1987) study of the two concluded:

> ... that both approaches: (a) are present focused, (b) are change, rather than insight, oriented, (c) view problems in their relationship context, (d) give directions, (e) assign tasks, (f) are interactional, or contextually oriented, and (g) are goal directed and concerned with the outcome of therapy. (p. 123)

Each of these models is similar yet distinct. Fish & Piercy (1987) believe that learning an integrated approach must at a minimum be preceded by an understanding of the theoretical distinctions between the two.

Both structural and solution-focused models has its adherents. However, as all clinicians are aware, what is effective with one family is not always effective with another. Thus, the expanded viewpoint offered by the integration of both approaches offers a greater potential for change for families experiencing problems.

The integration of a structural and solution-focused approach, in addition, to the use of a reflecting team, provides a further enhancement of multiple perspectives for problem solving when working with families who wish to reunify. "Multiple descriptions, while sometimes confusing, can enrich our vision and give us a better understanding of the whole process of therapeutic intervention and problem solution" (de Shazer, 1984, p. 36).

All four of the models in this literature review are guided by a family-oriented, change focus, that emphasizes promoting family empowerment, which is uniquely suited to reunification efforts. In conclusion, it is this writer's belief that the integration of all the above models provides for a more effective delivery of service.

Chapter Two

Intervention Methods and Evaluation Procedures

SETTING

The setting was The Family Centre of Winnipeg which is a not-for-profit accredited agency which supports and strengthens Winnipeg families through services and advocacy. The Family Centre of Winnipeg is comprised of three departments: In-Home Family Support Program; Special Needs Family Child Care Program; and the Counselling Department. The Counselling Department is fully accredited, adhering to strict professional and organizational standards. The Practicum utilized one of two specialized rooms designed with one-way mirrors and video taping capability.

CLIENTS

The client group for this Practicum consisted of eight families with a child or children who were of preadolescence age or older, who had been referred by the Child and Family Services worker assigned to that particular family. The targeted population were families who have a child or children in the care of Winnipeg Child and Family Services-East Area, or families who were facing the immediate crisis of the imminent removal of a child.

In order to provide 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 co-parent families.

There were, however, some requirements that had to be met in order to be eligible for the Practicum. For instance, due to the criteria specified in one of the evaluation instruments utilized in this Practicum the child(ren) had to be older than ten. The Practicum required that the child(ren) be accompanied by at least one parent or legal guardian. Another criteria for acceptance required that each member of the family identify a willingness to reunite or a desire to strengthen family ties. Thus, the Child and Family Services worker, family members, and The Family Centre of Winnipeg team had to be in agreement that the reunification process made sense to pursue at that particular point in the family's life. Lastly, an important component for the partnership between the two agencies entailed that the Child and Family Services worker be an integral part of the reunification process by attending at minimum the initial, middle and termination sessions along with the family and remain involved as the case manager.

PROCEDURES

The Child and Family Services worker would refer families who expressed a willingness to reunite or who wished to strengthen family ties even though some ambivalent feelings might exist. In order to be accepted

into the Reunification Program the Child and Family Services worker, the family, and the Reunification Team all had to be in agreement that a referral to this program was in the best interest of the family. The Child and Family Services workers continued to provide the primary case management and support to their families throughout the families involvement with the program. The C & FS caseworkers were invited to attend at least three sessions along with their families while treatment was in progress. The families referred to the program had to agree to being videotaped, and being observed by a team behind a one-way mirror, as well as, to participate in the research components allocated.

Interviews were approximately one to one and a half hours in duration, with the primary therapist remaining with the family at all times. The reflecting team observing the session behind the one-way mirror would exchange places with the therapist-family system about three quarters of the way through the session to deliver any comments, questions or recommendations. Following which, the therapist-family system would exchange places once again with the reflecting team to discuss any comments or speculations on the reflection. This writer had the opportunity to be the primary therapist for her own families and function as a member of the reflecting team for various other team members.

Interviews were typically arranged once every two weeks during the initial assessment phase, with longer breaks between sessions as

improvements were made. In all cases, a combination of structural and solution-focused therapy was utilized. The structural therapy model was primarily used for assessment purposes, and tracking family change. The solution-focused model organizes the types of questions asked and provides a context for acceptance and understanding.

All families were requested to complete the evaluative components of the Practicum. This included the completion of both a pre- and posttest measure of the Family Assessment Measure (FAM) by the parents involved in the program. As well, the Child's Attitude Towards Mother (CAM) scale had to be completed at the initial session as a pretest and again at the final session as a posttest by any of the youths involved in the Practicum. All of the Child and Family Services workers were also required to complete the Family Intervention Scale and the Family Assessment Form (FAF) at the beginning of the intervention and again at the point of termination.

PERSONNEL

This writer was the primary therapist in all the cases included in this Practicum. The primary supervisor was Dr. Don Fuchs, who is the Dean of the Faculty of Social Work at the University of Manitoba. Supervision took place at The Family Centre of Winnipeg and the University of Manitoba and included, discussion, case planning, and videotape reviews.

Clinical supervision was provided by Sara Axelrod at The Family

Centre of Winnipeg. Sara is the clinical supervisor of the Reunification Program and is recognized for advanced expertise in family reunification. Sara directly observed clients through the one-way mirror, and acted as a member of the reflecting team for the majority of families interviewed. She also provided clinical guidance, through telephone calls, while sessions were in progress. Clinical supervision occurred following sessions and during weekly team meetings throughout the duration of the Practicum.

The third member of the Practicum committee is Linda Campbell, who is an adjunct professor at the University of Manitoba in the Faculty of Social Work. Linda provided consultation on the evaluation components of the Practicum. Supervision occurred at The Family Centre of Winnipeg on an as needed basis.

Clinical guidance was also provided by George Enns MSW, during two workshops he facilitated at The Family Centre of Winnipeg during the course of this Practicum for the Reunification Team.

DURATION

This Practicum took place over a ten month period, from September 1996 through June 1997. The Practicum involved direct client contact one day per week over two academic terms.

RECORDING

Recording was completed by the writer on each session following a review of the videotape. Thus, the focus of each session and the interventions utilized were noted. Client progress was monitored based on the author's and teams' perceptions, as well as clients' verbal supplements, which were key to assessing the level of change.

EVALUATION PROCEDURES

The outcome of this treatment process was evaluated through the use of a pretest-posttest design applied to each family situation. The essential feature of this design is that clients are tested before and after the intervention. Thus the effect of the intervention is reflected in the amount of change from pre- to postintervention assessment. The original plan was for a pretest-posttest one group design in which aggregated data was to be compared using a paired T-test statistic. However, it soon became apparent that sufficient numbers would not be available for analysis, therefore, pretest-posttesting was done, and the analysis was limited to case studies.

This method has many limitations, for example, such a design does not rule out any threats to internal or external validity. Although, within the context of clinical work such a design does add to clinical impressions and provides a supplementary source of information on families. To offset the limitations of the design, efforts were made to secure measures that had

established reliability and validity, and for which appropriate norms were available. Standardized measures do allow some comparisons to be made regarding the impact of the intervention across families, however, a more rigorous design would have to be implemented to show causality.

The evaluation package included a pre- and posttest design using various standardized measures. The Family Assessment Measure (Appendix A) was completed by all the parents involved in the Practicum. The Child's Attitude Towards Mother Scale (Appendix B) was completed by the adolescents. Lastly, the Family Interactions Sub-scale (Appendix C) and the Family Intervention Scale (Appendix D) were filled out by the Child and Family Services workers.

The evaluation of the writer's skill development was made from various perspectives. The first perspective was through supervision with all three committee members which included live supervision, review of videotaped sessions, and consultation. The second source of evaluation was obtained from the feedback provided the members of the Reunification Team. Finally, the author's own self-assessment was taken into account to determine the level of progress achieved.

Chapter Three

Evaluation

CRITERIA FOR EVALUATION

Trute (1985) states that evaluation is considered a necessary component of sound social work practice, and is essential for determining and demonstrating the effectiveness of treatment. Ethically, social workers must be responsible for providing effective, cost efficient, treatment that has no known detrimental effects. In this imperfect world, however, present practice does not reflect this view. Trute (1985) notes that comprehensive measurement instruments and packages relevant to social work are not readily available, and utilization within a clinical setting often requires a time commitment greater than the benefits provided to both the practitioner and the client. In addition, evaluation is often perceived as a measure of a practitioner's skill level and competence rather than a measure of the relationship between the process and the outcome. The lack of knowledge, time, available measures, fear of statistics, perceived difficulty to develop and understand a research design, and perceived threats to competence all contribute to a lack of clinical evaluation practices in the field.

Trute (1985) believes that the system under consideration must include multiple levels of communication at both the verbal and nonverbal level. Thus, it is essential to use multiple measures in order to evaluate the

family system's therapeutic process. Trute (1985) states that "the scope of assessment must reach beyond the study of the behavior of one person to the behavioural patterns of several individuals in an interacting system" (p. 102).

Multiple measures were used in the evaluation of this Practicum. The measurement package uses triangulation as a means of evaluating the outcome of treatment from the parents' and childrens' perspective, as well as, from the perspective of the Child and Family Services workers involved in the Project. Ristock & Pennell (1996) define triangulation as: "using multiple methods in order to attain more thorough coverage of a subject by viewing it from different angles" (p. 51).

EVALUATION INSTRUMENTS

The Family Assessment Measure

The Family Assessment Measure (FAM) is a self-report instrument that assesses family strengths and weaknesses. The basic concepts assessed by FAM include: Task Accomplishment, Role Performance, Communication, Affective Expression, Involvement, Control, Values, Norms, Social Desirability, and Defensiveness. The FAM consists of three components: a General Scale; a Dyadic Relationships Scale; a Self-Rating Scale. Each scale provides a unique perspective on family functioning. The General Scale which focuses on the level of health-pathology in the family from a

systems perspective was the scale selected for this Practicum (Skinner et al., 1993).

Scoring

Skinner et al. (1993) state that the direct numerical sum of items on the FAM General Scale is called the raw score. An increase in the raw score corresponds to an increase in the number of family problems reported. Scores are normalized such that each subscale has a mean of 50 and a standard deviation of 10. The majority of scores typically fall between 40 and 60. Scores outside this range are likely to indicate that the member rating the family is reporting either very effective family functioning (below 40) or a disturbance in family functioning (above 60).

The FAM General Scale was completed by the primary caregiver which was usually the mother. The FAM was completed at the initial session as a pretest and again at the final session as the posttest. Assessments on the level of client change was determined by comparing group prescores and postscores.

Reliability

The results indicate that the FAM General Scale is a reliable measuring instrument. The internal consistency reliability estimates are substantial as the scale has an alpha coefficient of .93 for adults. The median test-retest reliabilities of the General FAM Subscales are: .57, mothers; and .56, fathers. These reliability estimates are considered good,

given the small number of items (5) on each Subscale. This indicates that an individual's report of family functioning reflects the overall evaluation across different time frames (Skinner et al., 1993).

Validity

The ability of an instrument to distinguish groups different in functioning addresses the issue of discriminant validity. In general, the FAM has shown sensitivity to group differences adequately in the research, differentiating the "problem" families from those that were not classified as "problem" families. Thus, the FAM has good discriminant validity. This scale has also been investigated with respect to concurrent, and construct validity. In general, the FAM was found to have high and significant correlations with other measures of family functioning providing support that the FAM is measuring family functioning (Skinner et al., 1993).

Utility

The FAM is an efficient and economic screening procedure that is most effective when used by clinicians as part of a total diagnostic package, or to monitor treatment progress. The FAM can be administered in a paper-and-pencil form using Multi-Health Systems QuikScore Forms. The QuikScore Forms include all necessary elements for administering, scoring and profiling the instrument.

The FAM may indicate general areas of strength or disturbance, however, the FAM scores cannot in and of themselves identify which

specific aspects within concepts of the model are strengths or weaknesses. In addition, the FAM scores reflect family functioning at the time of the assessment. Thus, a client's emotional state and/or level of motivation may influence the accuracy of the self-reported data.

FAM is designed to be conveniently used in clinical and research settings as a diagnostic tool, as a measure of therapy outcome, or as an instrument for basic research on family processes. Thus, the Family Assessment Measure provides an important complement to a clinical assessment by giving an independent and comprehensive overview of family functioning. FAM also offers considerable potential for providing the researcher with a carefully developed instrument for basic studies on family processes (Skinner et al., 1993).

Child's Attitude Towards Mother (CAM) Scale

Therapists working with families where conflictual relationships exist between parents and children are confronted with the task of finding instruments that accurately assess such problems and are suitable for use in clinical settings. This task is especially difficult if assessment of the relationship from the child's perspective is of major concern.

Giuli and Hudson have attempted to fill this void in clinical measurement by developing two instruments, the Child's Attitude toward Mother (CAM) and the Child's Attitude toward Father (CAF) Scales, to measure the extent, degree or severity of problems the child has with his or

her father or mother (Giuli & Hudson, 1977). As the families involved in this Practicum almost exclusively had only the mothers participate in the intervention, it was deemed unnecessary to utilize the CAF Scale.

Scoring

The scale is a paper-and-pencil questionnaires comprised of 25 items which require approximately five to seven minutes for children of average intelligence to complete. The scales are not recommended for children under age 12, as they may have difficulty with the scales' item language and response format. However, clinical and research experience suggests that they are useful for children as young as 10. Each item on the scale is a short statement about the respondent's parent or the parent-child relationship, such as: "I wish I had a different mother"; "My mother does not understand me"; and "I feel I can really trust my mother." Respondents are asked to indicate how frequently each item is true for their relationship with their mother by writing a number on a line after each item according to a Likert-type response format. There are 9 positively worded and 16 negatively worded items that are randomly mixed (Giuli & Hudson, 1977).

The CAM is scored by the reverse scoring of the positively worded items, summing the scores, subtracting the number of completed items, multiplying this figure by 100, and dividing by the number of items completed times 6. This will produce a range from 0 to 100, with higher scores indicating a more severe parent-child relationship problem. The

scores indicating a more severe parent-child relationship problem. The CAM has two cutting scores. The first is a score of 30 (± 5); scores below this point indicate absence of a clinically significant problem in this area. Scores above 30 indicate the presence of a clinically significant problem in this area. The second cutting score is 70. Scores above this point nearly always indicate that clients are experiencing severe distress with a clear possibility that some type of violence could be considered or used to deal with problems (Fischer & Corcoran, 1994).

The CAM Scale was administered to the adolescent clients of only those families who participated in this Practicum. The measure was completed at the beginning and the end of intervention. Client change was assessed by comparing the clients' overall scores pre- and postscores.

Reliability

The results indicate that both the CAM and CAF are reliable measuring instruments, as the CAF has a mean alpha of .95 and a Standard Error of Measurement of 5.16; the CAM has a mean alpha of .94 and a Standard Error of Measurement of 5.06. Both scales possess excellent internal consistency as the scales consistently achieve an alpha coefficient of .90 or larger. The measures also have excellent stability with one-week test-retest correlations of .96 (CAF) and .95 (CAM) (Giuli & Hudson, 1977).

Validity

The results indicate that both the CAM and CAF are valid measures of parent-child relationship problems. The scales have excellent known-groups validity, both significantly distinguishing between children who rate themselves as having relationship problems with their parents and those who don't. The CAM and CAF also have good predictive validity, significantly predicting children's responses to questions regarding problems with their parents (Fischer & Corcoran, 1994). This scale has also been investigated with respect to content, construct, and factorial validity. It nearly always achieves validity coefficients of .60 or greater (Hudson, 1992).

Utility

In addition to the psychometric properties the CAM and CAF have other characteristics that make them especially attractive for clinical use. The scales are short, and require only a few minutes to complete, they are easily administered, scored, and interpreted, as now have a useful set of comparison scores for several important subpopulations. The CAM and CAF scores are also useful for therapists wanting an indication of their adolescent client's distress level, scores above the specified criteria would alert practitioners to the possibility that some type of violence could be used to deal with problems. Most notably, the scales appear to accurately measure the construct that is of strong interest to most family practitioners

and researchers. Therefore, both scales are recommended for use in clinical and research activities (Saunders & Schuchts, 1987).

As the current research components utilized by the Reunification Program thus far do not take into account the child's perspective when working with families, it was deemed an area of research which would be a rich resource of information and be of great value to the program. These scales would enable clinicians to streamline their interventions where adolescent clients indicated it was warranted most following the initial session, as well as, serving as a measurement of change at the point of termination.

The Family Assessment Form

The Family Assessment Form (FAF) was developed by the Children's Bureau of Los Angeles to assess family functioning and to develop case plans for families at high risk of child abuse and neglect. It provides information from a single source, the service worker, on multiple dimensions of family functioning over a period of service delivery.
The service workers assess family functioning in regards to specified areas at the beginning of treatment and again at the end of the service period. Client change is determined statistically be comparing prescores and postscores (McCroskey et al., 1991).

Using service providers as the source of information has advantages

and disadvantages in regards to evaluation efforts. Some of the strengths include: the incidents of missing data is usually lower when service providers are the source of data, language on the questionnaire can be more abstract, and the response format can be made more complex. Precautions are required to control potential rater-bias. Thus service providers are asked to make absolute judgments of families' functioning in specific life areas at the beginning of intervention and to make another assessment at the end of treatment. In doing so, the providers would not have access to the premeasures when they completed the postmeasures, thus the postratings are "blind" (Taynor et al., 1990).

The FAF is organized around four broad topics that are further divided into specific areas. The Reunification Program assesses the outcome of intervention on only one topic area of family functioning referred to as Family Interactions Sub-scale. The Subscale is divided into three sections. The first section addresses the caregiver's interactions with the child(ren); the second addresses the child(ren)'s interactions with the caregiver; and the third pertains to the caregivers' relationship with one another (McCroskey et al., 1991).

Scoring

The FAF items are rated on a one to five basis, with higher scores indicating a more severe interaction problem. Workers can rate at the halfway point between two scores giving in effect a nine-point scale. A key

developed by workers gives detailed examples of the kind of observation, behaviors, or responses that would lead a worker to assign a particular score. The overall Subscale ratings are determined by the direct summing of the items. The summary ratings direct attention to both strengths and weaknesses, and they may provide some indication of outcome prognosis (McCroskey & Nelson, 1989).

This scale was completed by the Child and Family Service workers who referred families to the program at the beginning of the intervention and again at the point of termination. Client change was evaluated by comparing the caseworkers' pre- and postscores.

Reliability

The results indicate that the internal consistency of the instruments items were quite respectable with the exception of two additional scales involving the second caregiver. The low reliabilities for the scales assessing the "personal characteristics of the second caregiver" and the " second caregiver-to-child interaction" were a result of large amounts of missing data on all the scale items, thus resulting in an inadequate sample size upon which to base an analysis. The amount of missing data on the second caregiver was high because over 50% of the sample were single parent families (McCroskey et al., 1991).

Validity

The concept the FAF is intended to measure is family functioning,

which includes an ecological assessment of family strengths as well as problems. Taynor et al., (1990) notes that it is extremely difficult to conceptualize and develop instruments that can capture the complete interactive dimensions of family functioning. However, the authors believe that the multi-dimensionality of the FAF is more inclusive and reflective of an ecological orientation than other instruments currently used in the field (McCroskey et al., 1991).

Utility

The FAF may be used to help structure family assessment, to plan services, and to assess client change. As the FAF captures data regarding family functioning at intake and again at termination, it also provides systemic data that are used to evaluate overall program quality and achievement (McCroskey et al., 1991).

The Family Intervention Scale

The Family Intervention Scale is used to assess the outcome of family treatment in a family service agency where resources that can be allocated to outcome evaluation are scarce. This scale was designed to utilize the service workers as the source of information about families' functioning in five areas at which intervention was aimed. The Family Intervention Scale rates families on the quality of their role performance, their connectedness to the outside community and to friends, their ability

to provide for their own physical maintenance, their use of community resources, their skills for maintaining emotional well-being (Taynor et al., 1990). As the Family Intervention Scale utilizes service providers as the source of measurement it both strengthens and weakens evaluation efforts in the same manner as the Family Assessment Form.

Scoring

The Family Intervention Scale consists of five life areas, each of which is scored on an 11-point Likert scale, with lower scores indicating a more severe problem in that area. The total score is obtained by adding the items and dividing by 5 (Taynor et al., 1990).

The Family Intervention Scale was completed by the Child and Family Service workers who referred clients to the program, at the beginning of intervention, and again at the end of service provision. The effectiveness of the intervention is determined by comparing caseworkers' pre- and postscores.

Reliability

An assessment of reliability among items was conducted to determine the internal consistency of the items. In this analysis, the relationship between each item and the total score was determined. All correlations (Pearson r) were greater than .77, indicating that the items in the Family Intervention Scale measured the general area of family functioning that the service agency sought to improve during treatment. Reliability was also

assessed across raters. The interrater reliability (Pearson r) of the total score was .78 (p=.004). All correlations were quite respectable with the exception of the item measuring family connectedness. This item was retained as it represented an important area of intervention, obtained a good correlation with the total score, and showed statistically significant differences between pre and post scores (Taynor et al., 1990).

Validity

The Family Intervention Scale has good discriminant validity, significantly distinguishing between high and low functioning families (Taynor et al., 1990).

Utility

The Family Intervention Scale is a cost-efficient and meaningful assessment technique that may be used to effectively evaluate the outcome of intervention in a family service agency. While at the same time yielding insight into the severity of problems in the various life areas of family functioning. In addition, it provides evidence about the appropriateness of using service providers as the source of data (Taynor et al., 1990).

CASE RELATED INFORMATION

In addition to using the above measures, case related information was gathered and recorded each session. Standard agency information was

used to incorporate assessment information to supplement the writer's impressions.

Chapter Four

Case Examples and Results

INTRODUCTION

The following section will examine the results of the Practicum. A general overview of the results will be presented, followed by an examination of the utility of each evaluation instrument. Three cases examples have been selected which are representative of the diverse clientele this writer was involved with through this Practicum experience. These case examples will illustrate the implementation of the therapeutic approach utilized in this Practicum. The case examples will include clinical observations made, followed by the results of the various evaluation measures employed. Lastly, an examination of whether these measures were congruent with the writer's, the family's, and worker's perceptions of change will be explored. Refer to Appendix E for the family biographies of the five remaining families who received service as part of this Practicum.

Case example A will describe the intervention applied to an immigrant family whose estranged daughter is at risk of becoming further lost to the streets. Case example B will look at how the intervention was applied to a family with mental health issues who are wanting to reunify. The final case example C will explore the process of reconnecting a mother and son following the son's release from incarceration.

RESULTS OF EVALUATION

Treatment was provided to a total of eight families over the course of this Practicum. Of the eight, one (Family F) attended the initial session only. One (Family G) dropped out, and declined to complete the posttest evaluation components. One (Family H) dropped out, and was not able to be reached to complete the posttest component of the evaluation package. The C & FS worker for this family also did not complete the required research scales. As a result, this Practicum generated data for a total of five families.

The FAM-III: General Scale (Appendix A) was the most useful measure from a clinical assessment perspective. It generally provided a confirmation of the clinical impressions made at the initial point of therapy. However, this scale provided results consistent with the expected treatment outcome for only slightly more than half of the parents tested.

Of the seven parents who completed the FAM scales, four showed an improvement regarding family functioning on their Overall Rating when a comparison was made between pre- and postscores. On two of the Overall Ratings, the scores indicated that at the point of termination the family was not functioning as well as at the initial point of therapy, (Family A Mother & Family D Father). In one case, the parent rated the pre- and postscores as showing no change, (Family B Father).

The results of the Child's Attitude Towards Mother Scales (Appendix

B) found that the clinical assessments and observations paralleled the adolescents' pre- and postscores. The CAM was completed by four out of the six adolescents whose families completed the research requirements. One of the adolescents, (Family D), did not fill out a pretest because he was incarcerated for the majority of the treatment process offered to his parents. One of the adolescents, (Family E), dropped out of therapy following the initial session. Of the remaining four who completed the tests, two indicated an improvement in this area, (Family A & C). One indicated the parent-child relationship had became slightly more problematic, (Family E). One showed a dramatic rise in the level of difficulty experienced with the child's mother, (Family B). The results of the four completed CAM Scales appear to accurately reflect the adolescents' attitudes towards their mothers at the point of initial entry into the program and again at the point of termination.

The Family Interactions Sub-scale (Appendix C) was completed by the C & FS workers who referred families to the project. In order to be a more effective evaluation instrument, caseworkers should be more cognizant of their clients' issues. Also, families must be experiencing problems in areas tapped by the scales, in order to capture an accurate change result. The results indicated that the caseworkers' scores on the Family Interactions Sub-scale generally did not coincide with the clinical impressions and conclusions made, nor did these scores concur with the

verbal supplements provided by either the families or the caseworkers regarding the level of change that took place. The general trend of the workers' results indicate that their families were not functioning as well at the point of discharge as at the point of entry.

Of the eight workers involved, this scale was completed by only six of the case workers. The worker for Family F did not complete the posttest due to family only attending one session. The worker for Family H, whose family dropped out of therapy, also did not complete the posttest. Of the six families remaining, only two families were scored in such a way that indicated the clients had made improvements overall, in regards to their family interactions, (Family C & D).

The Family Intervention Scale (Appendix D) when also completed by the C & FS workers, again was not found to be particularly useful as a measurement of change for the families rated within this Practicum for the same reasons that the Family Interactions Sub-scale was not deemed particularly useful. A comparison of the pre- and posttest results on this scale only coincided with the clinical impressions and conclusions made on slightly more than half of the families who were rated on this scale.

This scale was completed by the same six workers who completed the Family Interactions Sub-scale. Of the six families rated, a comparison of the clients' pre- and postscores on three of the families indicated the clients had made improvements across dimensions, (Family C, D & E),

which is consistent with the families', and the C & FS workers' verbal supplements, as well as, the teams' clinical impressions. The three remaining families were rated as functioning less well at the point of termination on the areas specified, (Family A, B & G). The results for Family A & B, which did not show an improvement, did not concur with the verbal statements provided by these families or their C & FS workers regarding the progress made as a result of this program, nor did these results correspond with the clinical impressions and conclusions made. Family G, who dropped out of treatment, was also rated by the C & FS worker as functioning less well at the point of termination, which is consistent with the family's, and the C & FS worker's verbal statements, as well as the team's clinical observations.

In summary, the instruments did not appear to cause any undo stress or difficulty for the families or the case workers involved in this Practicum, nor did the instruments interfere with or interrupt the treatment process. The families and workers generally supported the principle of evaluating the effectiveness of service in addition to their own self-reports.

It is this author's opinion that the FAM III may be more useful as a clinical assessment measure than as a program evaluation tool. The usefulness of the FAM scale as an assessment tool only came into question when it was utilized with Family B, as this family suffers from mental health issues. It would appear that this scale was too difficult to

comprehend in this case, resulting in their pretest ratings on the FAM being inconsistent with the clinical observations made and the verbal supplements provided by this family and their worker. As the assessment and evaluation agenda were not always consistent with the results, it is this writer's opinion that a scale filled out by the clinician such as the FAM Clinical Rating Scale or the Family Interaction Coding System may be better suited to capture the evaluation agenda.

The CAM Scale was found to be an effective evaluation measure, as it supported both the childrens' reports of change, and the clinical observations and conclusions made. The only difficulty observed with the CAM Scale was when it was administered to an adolescent, (Family A) whose first language was not English, and whose educational skills were questionable. In all the other cases there appeared to be little difficulty for the adolescents in interpreting the scale.

C & FS workers are often found to be more reliable in completing the required research for the program, than clients. Although data results from the C & FS workers would be useful to the program, the current scales used often provided inconclusive information between pre- and posttest results.

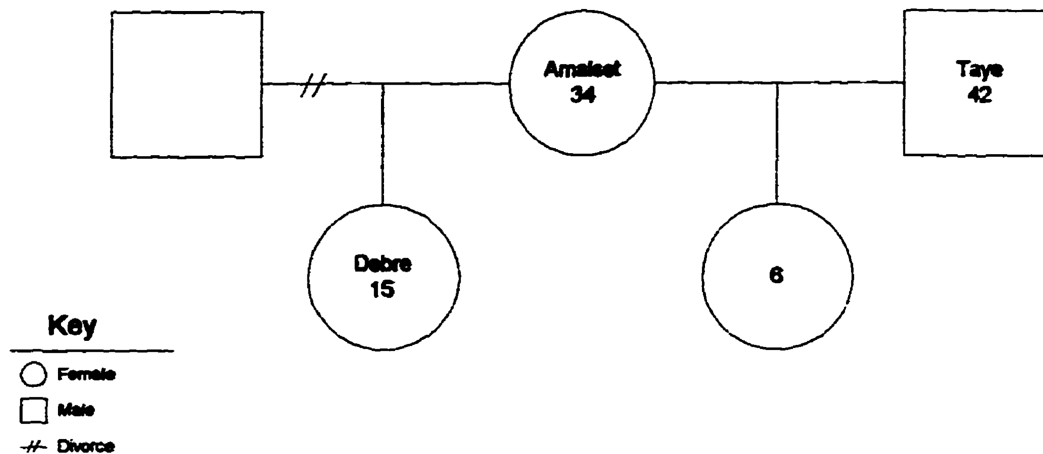
One possibility is that, at the point of pretesting the workers may not have been aware of some of the issues that their families struggled with. As a result of the workers attending sessions along with their families, these

problems became either clarified or more amplified, hence the incongruent scores. The dimensions tapped by these scales are not always relevant for families who are attempting to reunify. Such relevant treatment issues as the level of parent-adolescent conflict, trust, problem-solving skills, school attendance, and age appropriate rules and expectations for the adolescents, were not measured by these evaluation instruments.

CASE EXAMPLES-INTRODUCTION

The selection of the case examples was based on a number of factors. First, selection was based on the writer's desire to present a variety of family issues that were relevant to reunification work. Secondly, in order to demonstrate the versatility of the model the families were selected based on family form, social class and cultural diversity. Lastly, the selection of case examples was based on the families' differing reunification goals. All three cases will provide an illustration of the of the therapeutic approach used in this Practicum.

Case Example-A



For safety reasons, seven years ago the mother and stepfather immigrated from their homeland, Ethiopia, to a foreign country. After two years, they immigrated to Canada. In order to spare Debre from the long and arduous journey, she was left behind in Ethiopia with her maternal grandmother. After several years of attempting to have Debre sponsored to rejoin her mother and stepfather, she eventually arrived in Canada in 1994.

Debre experienced a great deal of difficulty adjusting to her new country as she had a number of challenges to contend with, such as: acquiring new language skills; becoming acquainted with new cultural customs; transitioning to a lifestyle where education was highly stressed; and adjusting to being rejoined with her mother and stepfather, in addition to meeting her new little sister for the first time, without the security of meaningful relationships with those she left behind. Thus, Debre's transition to Canada was fraught with complexities.

Child and Family Services became involved when Debre contacted

them directly after running away from home less than two years after her arrival to Canada. Debre went into care as a result of refusing to return home, and was placed in a temporary foster care arrangement. The C & FS worker's initial plan was to have Debre returned home promptly, and to give her as little choice as possible in the matter. The parents initially were in agreement with this plan, however, they changed their minds as the time grew nearer for Debre to be returned, as they believed Debre would only respond negatively to being forced to return home.

The worker then decided to refer the family to the Reunification Project in an attempt to assist this family in learning how to communicate with one another more effectively, with the ultimate goal being that Debre return home successfully.

Amalset and Taye, the mother and stepfather of this family of four agreed to attempt reunification on the grounds that Debre not be forced into returning against her will. The first session included the parents and the worker, minus Debre, as the worker was unable to track her down in time for the meeting. The parents' described their agonizing decision to leave Debre behind with Amalset's mother out of concern for their daughter's safety as they were immigrating to a country that was in a state of civil war, and the toll this took on the mother for all the years they were separated as a result. They described Debre's upbringing under her grandmother's care as being exceedingly lenient, as the grandmother was

unable to enforce school attendance or responsibilities around the home. Thus, Debre was left to make virtually all her own decisions at a young age, and lived a lifestyle unlike any of her peers. Taye stated they were expecting alot from Debre when she arrived in Canada at the age of twelve, as she was described as a being a "star" back in Ethiopia, one of the most outstanding kids in their hometown of 15,000.

The parents were united in their desire to have Debre returned from being in care, as they were concerned about the influence of the negative peer group Debre had quickly become entangled with. However, the mother made it very clear that if reunification was not Debre's goal as well, she was prepared to enter counselling in order to simply reconnect with her daughter.

They described Debre's behavior in the home to be rebellious and disrespectful, which came as a complete surprise to both parents, as respect was highly valued within the family and within their cultural background. In addition, her school attendance quickly deteriorated, as they believed Debre did not feel equipped to handle the structure or curriculum a grade six class demanded.

The team reflection for this session was geared towards attempting to make this couple feel heard and understood, and to empathize with their current situation. The family was complimented on their unrelenting pursuit to have their daughter reunited with them, and on the depth of feelings

within this family. The parents were also asked to consider what it would take to have Debre rejoined with the family, and what changes each of them would have to make to reach this goal?

The parents did not respond to the reflection, but rather reiterated their concern about Child and Family Services previous attempt to have Debre coerced into returning home. They felt this had undermined the progress they were making with Debre during previous family meetings held at C & FS and did not want this process repeated. It was determined that Debre would be invited to attend the following session without her parents in attendance, in order to give her a chance to become familiar with our program without the added stress of facing her parents as Debre had no contact with any family members for several weeks at this point.

The second session was attended by Debre and her C & FS worker. The primary focus of this session was to join with Debre and to provide her a forum to discuss any of her concerns. She was initially cautious in her responses although as the session unfolded she used this opportunity to inform us that she considered her grandmother to be her real mother and that she did not want to be reunited with her family in Canada. She described her home life with her mother and stepfather as being fraught with conflict, and stated that she felt most accepted with her newly acquired peer group. Debre stated she didn't understand why the adults in her life are so concerned with her choice of friends, as she herself has no

worries about her current state of affairs.

The reflection team complimented Debre on being a strong young woman, who is clear about her likes and dislikes. They stressed that people are worried because she is young she won't always know what is best for herself, and that it must be difficult for her to accept these messages given that she has been independent for such a long time. They invited Debre to come back next session along with her parents, in order to give her an opportunity to have her parents listen to some of her concerns. The team stressed their hopes that all the members of the family will be able to listen to one another in a better way. Debre did not comment on the reflection but did agree to participate in another session along with her parents.

The third session was attended by both parents and Debre, the focus of this session was to attempt to clarify each of family member's goals. The session began with the mother and daughter hugging affectionately as they had not been in contact for some time. When questioned about the goals that each of them had, both mother and daughter stressed that they don't feel understood or respected by the other and that this was an important goal for each of them, and both stated a desire for increased communication in the family. During the session Taye reiterated some examples of Debre's apparent lack of respect which resulted in Debre becoming quite agitated and disrespectful within the session. Amalset appeared to be at a complete loss to comprehend some of her daughter's

behavior especially in regards to her level of anger. Debre's behavior was reframed by the writer as possibly being feelings of hurt turned into angry behavior, which Debre neither confirmed nor denied. This line of questioning resulted in Mom openly discussing her worry and hurt about Debre's welfare especially now that she is in care, in addition, she stressed to her daughter the extent of her love towards her. This resulted in Debre "softening" her demeanor. The reflection team was called in after Mom made a statement about the importance of family, as no other family members lived nearby.

The reflection team noted the strong bond between mother and daughter, and highlighted the exceptions when Debre did show respect towards the family. They also noted the difficulties involved for a teenager coming to a new country and invited the family to discuss this further in future sessions, along with the important dialogue they started in this interview. When the family returned from behind the mirror their only comment was an unanimous agreement to come back for further meetings to continue their conversation.

The fourth session was attended by the mother and daughter only, as the stepfather was unable to attend. The focus of this session revolved around clarifying the diffuse boundary around the spousal subsystem, as Debre was often invited by her mother to become a part of the executive decision making within the family. For example, Amalset would consult

with her daughter on whether Debre felt her parents' marriage was still viable. The session also highlighted Debre's pattern of switching schools and foster placements when she became disillusioned with these areas of her life. Debre was challenged on whether her method of problem solving, by premature termination of difficult relationships or situations was working for her as a way of resolving issues. She was given a "do something different task" in order to experiment with change around this repeating pattern of ineffectual behavior. In addition, Debre was encouraged to utilize her fierce independence, as a way of creating some distance between herself and the negative peer group she had become entangled with.

As it became clearer to the team that within the spousal subsystem the mother was the "customer" and the stepfather was viewed as a "visitor", the family was invited to consider having only the mother and daughter attend future sessions, in addition, it was hoped that meetings with the mother and daughter alone would strengthen their bond.

Debre and her mother attended three more sessions together, for a total of 8 sessions for this family altogether. As the level of communication became more direct and open between mother and daughter there was a clarification of the boundaries between the subsystems. The improved flow of communication allowed Amalset and Debre to develop a clearer sense of their relationship with one another.

The second to last session also included the C & FS worker who was in the process of transitioning to another position. The worker's hope was to transfer Debre immediately into a more appropriate foster home before transferring the case to a new worker, as the home Debre was in currently was not deemed a good match and was only a temporary arrangement. A consensus was reached that Debre should remain in care for the time being as they did not want to jeopardize the progress that was being made in regards to the newfound relationship between mother and daughter, and due to the fact that Debre continued to remain adamant that she preferred to live outside of the family home.

The final session was held one month later with the C & FS worker, the mother, Debre and her new foster mother also in attendance, in an attempt to examine the changes that have occurred within the family and to explore the challenges and goals that lie ahead. At this point all members present felt that Debre had made some important changes in her conduct, as her running behavior was no longer a concern, nor was her association with a negative peer group an issue. In addition, there was an observable difference in the way the mother and daughter interacted as the level of positive communication had clearly increased. As well, contact between mother and daughter had greatly improved as phone contact and visiting were occurring on a consistent basis. The mother also indicated that the level of trust between them had grown, as Amalset no longer felt Debre

was being dishonest towards her. Amalset emphasized her immense degree of relief to know that her daughter had settled down in placement and was making consistent progress, she also stated her support of the foster placement and her impression of the important role the foster mom was playing in her daughter's life. Debre's behavior in the session indicated that she was also proud of her recent accomplishments and that she enjoyed the compliments that were directed her way.

When they were asked what had been the most helpful aspect of the therapy process, the mother responded by thanking everyone on the reflecting team including the writer for their assistance in helping them to establish a healthier relationship with one another. She also thanked the C & FS worker for finding a placement where her daughter could flourish. When asked what might have been more helpful, the mother stated that it would have been more helpful at the beginning of the program if more time would have been taken, to explain to the family the distinction of roles between the Child and Family Services worker and the writer, as this was not clear to the mother until some time into the program. Both the C & FS worker and the author took ownership for failing to make this clearer to the family right from the start, and thanked the mother for her important feedback.

Data Findings

The mother's overall rating on the FAM questionnaire remained within the average range, and showed little change at the point of termination. In regards to the individual Subscale ratings, the Task Accomplishment Subscale displayed an increase from 43 to 53, between pre and posttesting, however, the latter score is still within an average family functioning range. The scale found no change in Role Performance between pre- and posttesting, which was rated within the problematic range. This is perhaps due to the mother feeling that she isn't capable of performing her role as a mother to her adolescent daughter, as her daughter remains living outside the home. The mother's score on the Communication Subscale showed improvement between pre and posttesting, which is consistent with the family's and the writer's observations. The Control Subscale was also identified as a problem area by the mother on both the pre- and posttest, this is congruent with the mother's statements during the intervention that power struggles were abundant in this family between Debre and her parents, and that despite strides made in communication and overall behavior it continues to be an area where further work is warranted. The mother's pretest scoring on the Values and Norms Subscale was surprisingly low given the discrepancy between her daughter's behavior since her arrival to Canada and the family's value system. The posttest results on this subscale however, increased significantly from a 51 to a 69, which is consistent with the mother's concerns about her daughter's

TABLE 4.1

Case Example A

Measure	Surveyed	Scores	Clinical Interpretation
Family Assessment Measure: *General Scale*	Mother Father	Pre - 56 Post - 58 Pre - 49 Post – N/A	Score falls within the average range albeit skewed towards the problematic end of the scale.
Family Interactions Sub-scale: *Interaction Toward Child*	C & FS worker	*Mother* Pre – 3.21 Post – 3.71 *Father* Pre – 3.71 Post – 3.93	0.5 shift towards the negative end of scale. 0.22 shift towards the negative end of scale.
Family Interactions Sub-scale: *Child to Caregivers*	C & FS worker	*Mother* Pre – 3.33 Post – 3.83 *Father* Pre – 4.0 Post – 4.5	0.5 shift towards the negative end of scale. 0.5 shift towards the negative end of scale.
Family Interactions Sub-scale: *Caregiver to Caregiver*	C & FS worker	*Mother* Pre – 3.17 Post – 3.67 *Father* Pre – 3.5 Post – 4.0	0.5 shift towards the negative end of scale. 0.5 shift towards the negative end of scale.
Family Intervention Scale	C & FS worker	Pre – 5.6 Post - 4.6	The average score dropped from the range showing a balance between satisfaction and distress to the moderate distress level.
Child's Attitude Toward Mother Scale	Daughter	Pre – 54.67 Post - 28.67	Results indicate a shift from the clinically significant problem range to the absence of a clinically significant problem in this area.

conduct, and indicates that this is still and area of concern for the mother. A comparison of the results also indicated a decline in both the Social Desirability and Defensiveness Subscales, which may imply that the mother was less concerned with disappointing the writer, and that she felt less of a need to be perceived as healthy at the point of termination.

As the stepfather only completed the pretest a comparison of client's scores cannot be analyzed, however, it should be noted that on the pretest the stepfather scored all of the Subscales within the normal parameters, with the exception of the Values and Norms Subscale showing that this is problem area. This is consistent with the statements he made during the assessment phase of treatment regarding his stepdaughter's behavior being incongruent with his cultural norms. One strength worth noting is that the parents rating on the affective expression subscale at the initial point of testing is shared equally amongst the parents.

The daughter's ratings on the CAM Scale indicated that at the point of initial testing her score was within the clinically significant problem area, however, this dropped substantially on the posttest, to the point of indicating an absence of a clinically significant problem. This is congruent with the observations made by all the parties in attendance during the termination session.

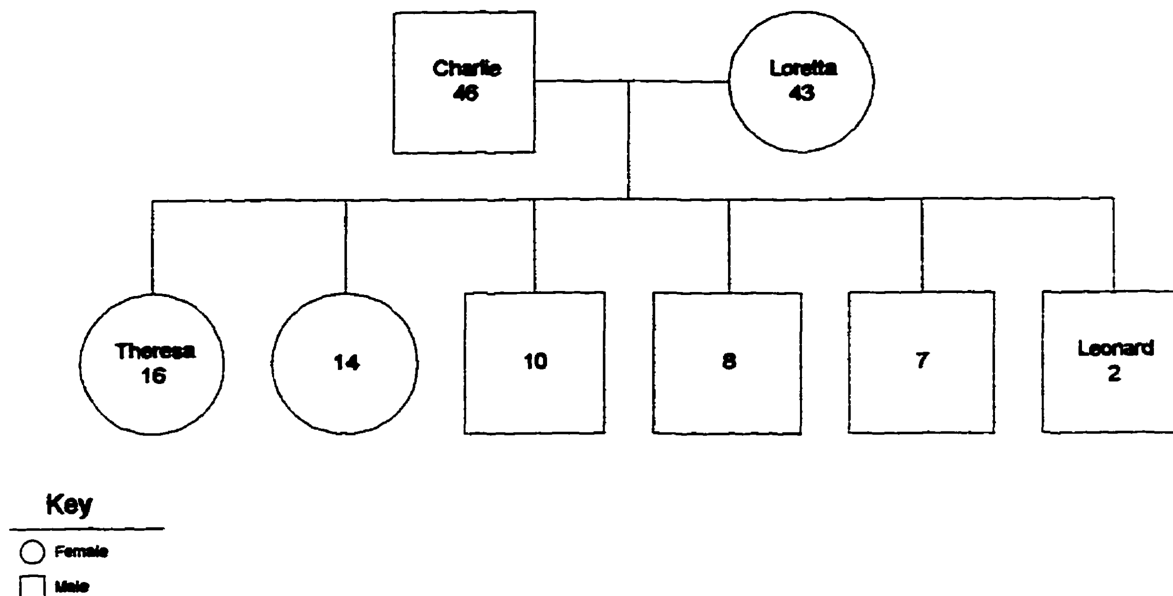
The C & FS worker did not rate this family as a problem family on the two brief scales that assess the family's level of functioning before and

responsible for the mother's elevated scores at the point of completing the research.

It is interesting to note that the C&FS worker's pretest scores were rated as less problematic at the initial point of therapy than at the end of therapy. This may be due in part to the fact that the worker had only had limited contact with the family prior to referring them to the Reunification Project, and thus became more aware of the issues facing this family through attendance at these meetings.

In summary, although the evaluation measures indicate overall functioning within the average range, the scores are skewed towards the problematic end of the scale. Thus, it is this writer's opinion that further clinical intervention is warranted with this family, especially in light of recent events. Furthermore, even though Debre was not reunified with her family, the family was assisted in reconnecting the mother/daughter bond, which will hopefully prove to be an anchor for Debre in the uncertain days ahead.

Case Example-B



The B family was referred by the family's C & FS worker to the Reunification Program in an attempt to assess the parents' readiness to be reunified with their daughter. The mother of this family is socially and mentally delayed, the father appears somewhat socially delayed. The mother's behavior during sessions would reveal a pattern of her frequently becoming fixated on a particular question despite its irrelevance to the topic at hand. In addition, she would respond by denying accusations made by her daughter and husband, and then later contradict her own self-denial. Theresa was recently assessed as functioning at an intellectually deficient range, and is somewhat emotionally and socially delayed for her age.

Theresa along with her four younger siblings were taken into care in 1992, due to concerns centered around poor parenting, allegations of

contact with their children, that eventually went as far as the Supreme Court. As a result, an agreement was ultimately reached with C & FS, whereby the parents agreed to relinquish further court action for some contact with their children. A decision was made by C & FS to begin 2 hour visits between the parents and all of their children once a year at C & FS. There was also a decision made to look at the possibility of reunifying Theresa with her parents, due to the fact that Theresa's initial foster placement in B. C. broke down, as the foster parents separated, which required relocating Theresa to Manitoba. Upon Theresa's return she was placed with her two brothers, but due to the high needs of one brother, this arrangement was not viewed as in the best interest of either Theresa or the foster parents. Additionally, she was the only one of the five siblings in care who thus far showed a desire to be reunified, she is also the highest functioning of all the kids in care in this family, the other four children all have special needs.

The family's attendance at sessions was very consistent exhibiting high motivation and effort as they were seen a total of 15 sessions, with only one cancellation over an eight month period, due to poor driving conditions. The first session was attended by the parents, Theresa and the C & FS worker. This session focused on allowing the family to tell their story. The session also provided the parents and Theresa a beginning opportunity to become reacquainted, as the parents had only recently begun

separate visits with Theresa after a four year estrangement. The C & FS worker was asked to elaborate on how visits have gone thus far, and what concerns their agency had regarding visitation, of which there were none. The parents were asked what they intended to do differently when interacting with Theresa. Charlie was able to elaborate on the positive changes they intended to implement, such as, understanding that their daughter has individual needs, that more negotiation and listening need to occur, and that age appropriate rules and consequences will need to be established rather than relying on bribes or physical punishments as they had done in the past. The parents, especially Loretta, described the extracurricular activities they hoped to enjoy with their daughter in the upcoming months, including shopping, going to the movies, and eating out. She also stressed the enjoyment she derived from singing with the family. Prior to the reflection team commenting on the session, Theresa was able to appropriately ask her parents why they had treated the children in such a hurtful manner. Charlie responded to the question by taking responsibility for his past mistakes and by assuring his daughter that his parenting abilities had improved, which appeared to satisfy Theresa's query.

The reflection team commented on the extent of losses this family has had to endure, and complimented the parents on their perseverance to regain access to their children. The team also reflected on the healthy changes that have already taken place within the family, and noted that the

parents did not hurt their children intentionally. Theresa was complimented for finding the courage to ask a difficult question, and Charlie's response was viewed as being handled extremely well. A recommendation was made by the team to ensure that consistent visits begin to be implemented.

Following the reflection, the family appeared extremely grateful for the reflection teams' comments. It quickly became very apparent to the team that this empowering format was a new experience for this family. The parents' comments and behaviors throughout the session clearly indicated that they had become accustomed to behaving in a disempowered fashion due to their experiences with C & FS, for instance, the family would often ask if it was appropriate to bring up certain questions as this was a learned response from their interactions with C & FS. As well, they appeared pleasantly suprised to discover that the frequency and duration of visits would be left up to the family to determine, rather than the family being directed by other professionals, a pattern which they had come to expect. Loretta also disclosed their fear of doing anything "wrong" with regards to their parenting. This fear was so powerful that she believed any suspected wrongdoings would result in the immediate apprehension of their youngest child by C & FS.

It became clear to the team following the initial session that the parents in this family continue to struggle with proper limit setting for their children. Evidence of this difficulty was displayed by their over-

indulgent manner towards their youngest child during sessions. For example, rather than setting limits for their son during the meeting they would often attempt to placate Leonard with candy when he became extremely disruptive, in what was often a futile attempt to have him behave in certain ways.

Shortly after therapy began, a meeting was arranged with C & FS which included Sara Axelrod, the C & FS worker, and the C & FS supervisor for this family along with the writer. The purpose of this meeting was to clarify the treatment goals and to coordinate services in the best interests of this family. The C & FS agency had many concerns about the mother's ability to parent, especially in regards to the youngest child. In order to address these concerns it was determined that more resources were required for this family. Therefore, C & FS agreed to make arrangements to have a teaching homemaker put in place, as well as, daycare for Leonard. All the above parties agreed that the primary treatment goal was the successful reunification of Theresa with her family, including the B family's request that Theresa return home at the end of the school year. Lastly, it was agreed that the C & FS agency would no longer take a central position with this family, as their dealings with them to this point had been excessive. The hope was that with less involvement with the C & FS agency, and adequate resources in place, the family would learn to become self-sufficient.

Following the assessment phase of therapy, the family was able to take over the decision making process around the pacing of visits with Theresa, which they were able to handle quite nicely with little guidance from the team. During the initial assessment phase of treatment, brief visits occurred following the session, however, this soon expanded to planned day visits at the parents' home, and eventually led to overnight stays on weekends. During the family's final two months in the program every weekend was spent together. However, as the visits increased in duration, Theresa's anxiety level increased proportionally. These reactions were normalized throughout the sessions, given the exceptional circumstances that attributed to the lengthy separation in the first place. As the visits became more of the norm, Theresa's adverse reactions became less frequent.

The remainder of the reunification sessions focused on assessing visits and intervening from a structural perspective, as well as, utilizing solution-focused questions to highlight exceptions and amplify problem-solving abilities. As visitation increased, a conflictual relationship arose between Theresa and her mother, which formed a triangulating pattern within the family. According to Theresa, during visits her mother would not respect her privacy in regards to conversations Theresa would have with others, as well, Theresa would become extremely frustrated with some of her mother's inappropriate comments. The pattern became that the father

would get pulled into these fights and end up allying with his daughter against the mother. Eventually, as Charlie and Theresa grew closer, they would often share private jokes precluding Loretta, in addition to having discussions that more appropriately belonged to the marital subsystem. The result was a cross-generational coalition between father and daughter, which excluded the mother. This pattern lead to the mother and daughter interacting in more conflictual ways and mother feeling left out and unsupported.

The goal of treatment in this phase became the altering of boundaries and the realignment of subsystems within the family. Therapy consisted of elevating the parental hierarchy within the family, as Theresa would often assume a parentified role. Concurrently, treatment consisted of clarifying the boundaries around the marital subsystem, despite the apparent unresolved issues in the marriage. Towards these goals, Theresa was occasionally asked by the writer to leave the interview for brief periods, in order to impress upon the parents the necessity of them appearing and behaving as a parental subsystem towards their daughter. Charlie was also encouraged to help alleviate some of the blame Theresa would direct towards her mother by allying with Loretta through the use of supporting messages to his wife. At the same time, discussions took place regarding appropriate messages they could give their daughter when she was crossing a boundary. During sessions with all three family members these newfound

skills were reinforced by the therapist. Treatment also focused on increasing the proximity between the mother/daughter subsystem. Thus one of the interventions employed was asking the mother in concrete behavioral terms to hug her daughter during sessions when it was appropriate to do so, which resulted in decreasing the tension between them. The women were also encouraged to find mutually satisfying activities they could enjoy together that excluded other members of the family, they agreed to attempt such activities as baking and going to movies together. As a further reinforcement, the reflection team would then support these interventions and subsequent behavioral changes through the messages they would deliver in order to highlight positive change.

The final termination session was attended by the family, the C & FS worker who had not been a part of these sessions for months, as well as, a new C & FS worker was introduced to the family during this session as their worker was being transferred. The focus of this session was to celebrate with all those in attendance, the level of change that has occurred within this family since their referral, as well as, Theresa's move home during that same week.

The family was asked to highlight the progress that each family member had made to the C & FS workers, as a way of reinforcing the abilities of this family to implement change. Some of the highlights included: strengthened family ties; increased communication within the

family; Theresa's relationship with her mother became less reactive, as Theresa became more accepting of some of her mother's limitations; and the family's ability to act more independently and utilize problem-solving skills when issues arose. The family's previous C & FS worker complimented the family on their accomplishments, as well as, thanking the reunification team on facilitating the changes within this family.

The session also focused on assisting the family to make arrangements with their new C & FS worker regarding various details of importance to the family. At the same time, allowing the new worker to clarify her role within the family, and determine appropriate resources in the upcoming months.

The session included a reflection from the Team that normalized some of the reactions that Theresa is likely to exhibit in the following months, in addition to stressing the importance of C & FS maintaining their newly established role with this family, and lastly, praising the family for all their perseverance and hard work. The session ended with Loretta reading a letter to their previous C & FS worker thanking her for believing in their family, as well as, singing a song in celebration.

In summary, this family responded well to a solution-focused approach. Strengths were highlighted which provided new information about themselves and their abilities. In addition, as this approach is based on an empowering principles it served a useful purpose of highlighting the

progress of this family and their ability to overcome problems in therapy. They also responded well to structural change within the family, as clearer boundaries and a more appropriate executive subsystem has developed.

Data Findings

Loretta's scores on the FAM Scale indicated that her comprehension level was not adequate. Her scores on the pretest were highly skewed indicating functioning varied from the very effective range to the highly problematic range. On Loretta's posttest the scores all fell within the above average range.

Charlie's scores on the FAM pre- and posttest are also questionable, as his scores did not indicate any noticeable change despite his verbal statements to the contrary. In addition, his scores fell within the above average range for family functioning on both the pre- and posttests. His scores on the Defensiveness Scale are skewed quite high on both the pre- and posttests, which brings the validity of his responses into question.

Theresa's evaluation results indicated her pretest score on the CAM Scale went from the total absence of a clinical problem to the severe stress level by termination. Due to the extremity of the scoring between pre- and posttesting it brings these results into question.

The C & FS worker's evaluation results also do not coincide with the verbal comments made by the worker at either the point of initial work

TABLE 4.2

Case Example B

Measure	Surveyed	Scores	Clinical Interpretation
Family Assessment Measure: *General Scale*	Mother Father	Pre - 57 Post – 37 Pre - 36 Post – 36	The mother's comprehension level was not adequate. Scores fall within the very effective family functioning range.
Family Interactions Sub-scale: *Interaction Toward Child*	C & FS worker	*Mother* Pre – 2.64 Post – 3.25 *Father* Pre – 1.79 Post – 2.0	0.61 shift towards the negative end of scale. 0.21 shift towards the negative end of scale.
Family Interactions Sub-scale: *Child to Caregivers*	C & FS worker	*Mother* Pre – 1.5 Post – 2.75 *Father* Pre – 1.5 Post – 2.0	1.25 shift towards the negative end of scale. 0.5 shift towards the negative end of scale.
Family Interactions Sub-scale: *Caregiver to Caregiver*	C & FS worker	*Mother* Pre – 1.17 Post – 2.5 *Father* Pre – 1.67 Post – 2.83	1.33 shift towards the negative end of scale. 1.16 shift towards the negative end of scale.
Family Intervention Scale	C & FS worker	Pre – 7.2 Post – 6.6	The average score dropped from the range showing moderate satisfaction to the range showing a balance between satisfaction and distress.
Child's Attitude Toward Mother Scale	Daughter	Pre – 2.67 Post – 72.0	Results indicate a shift from the absence of a clinically significant problem to the range of severe stress in this area.

with this family or by the end of the project. The worker's perception on the Family Interactions Sub-Scale show the father's scores as being highly skewed towards the positive end of the scale during the pretest rating, and moving slightly towards the negative end of the scale although still well within the middle range at termination. The mother was also rated on these same scales as showing slightly more negative interactions by the point of termination, but overall still scoring within the mid range of functioning in this area. The worker's pre- and posttest ratings on the Family Intervention Scale are equally baffling. The family was rated in the midrange of family functioning, with the posttest indicating a slight decline in functioning on the five areas covered.

Conclusions

The family's and the C & FS worker's results on the evaluation instruments did not support the clinical impressions or observations made regarding this family. Nor did these results correspond to the verbal statements made by either the family or the C & FS worker, regarding the family's level of functioning either at the beginning or the end of treatment. It is this writer's opinion that the research scales were at a comprehension level that did not match this family's ability level. In cases where there are mental health issues or where clients are poorly educated, more simplified research tools should be utilized in order to be effective in capturing the

change level. An example of this would be to employ a research scale such as a brief Likert scale that uses plain language and asks simplified questions.

Both of the parents' posttests rated their family as functioning within the above average range, which may be a result of them wanting to be perceived as a very healthy family, in order to increase their chances of regaining custody of their children who remain in care.

Theresa's scores on the CAM indicated that she did not perceive any difficulty in regards to her relationship with her mother at the beginning of therapy, however, at the end of treatment she rated this same scale as being within the severe stress range. It is this author's opinion, based on verbal supplements provided by Theresa, that these scores are indicative of the absence of a relationship between Theresa and her mother at the point of initial referral due to their lengthy separation and lack of a relationship. As Theresa's pretest scores did not indicate any specific problems in relation to her attitude towards her mother. However, by the end of treatment, as a result of increased time spent together, Theresa was able to acknowledge that this relationship was problematic for her.

The C& FS worker's pretest results indicated the worker saw this family as being quite healthy at the point of initial referral, which did not correspond with the worker's initial statements regarding the family's level of functioning, nor did these scores reflect C & FS position at that time to

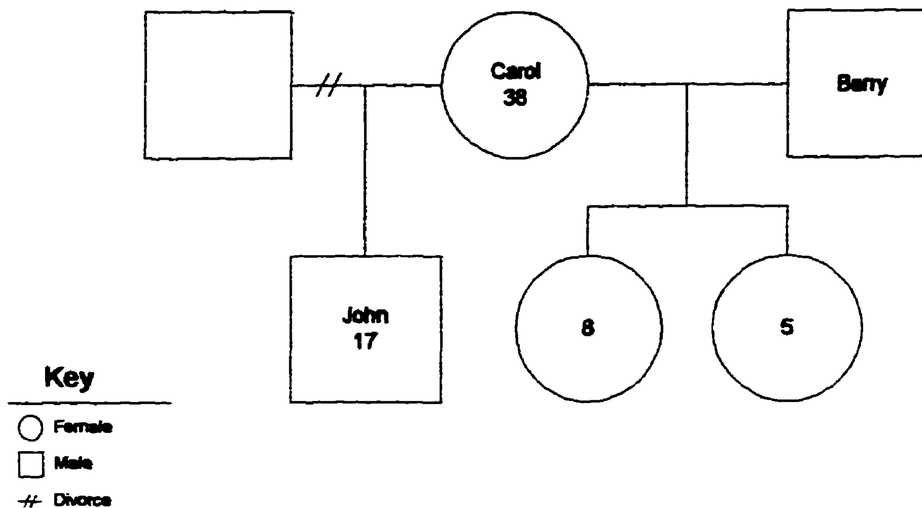
give these parents as little autonomy as possible. In addition, these scores are a complete contradiction to C & FS previous decision to have five of the children in this family placed under permanent guardianship, due the agency's belief that the parents' in this family were unable to raise their children.

During the termination session the worker commented on the positive level of change that she witnessed within the family since their involvement with the project, although the posttests completed by the same worker indicated that the family was not functioning as well as at the point of initial treatment.

One reason that the caseworker's results were not conclusive may be that the caseworker was focusing only on the family's strengths when completing these scales, rather than a overall view of the family. Lastly, it is possible the worker did not fully understand the meaning of the questions on each of the scales, and thus her results do not reflect her verbal statements.

In comparing the statistical to the clinical significance, this family showed clinically significant change, however this conclusion was not supported by statistical measurement. A more sensitive measurement tool, for the family, might have been able to capture a quantifiable result of change.

Case Example- C



Carol and her son John were referred to the project in an attempt to rebuild the relationship between them. John was under a voluntary placement agreement with C & FS, and had recently been released from several months of incarceration due to his drug use and subsequent criminal involvement. Many of John's crimes were thefts committed against the family and the family business. At the point of initial therapy there had been no contact between the mother and son for a one year period.

The first session was to be attended by Carol, John and the C & FS worker, although the beginning of the first session included only the mother. While waiting for the other two to arrive, Carol described to the team some of John's past behaviors which included extensive criminal activities such as derailing train cars, property damage to their home, forging family cheques, and draining the family's bank accounts by devising

elaborate schemes in order to gain access to bank card numbers. The C & FS worker called midway through the session to inform us that John did not show up at the designated meeting place as planned, and thus the worker had decided to forgo attending the reunification meeting. Carol was visibly disappointed by this news, and stated that she had hoped that this time things would have worked out differently between them. However, shortly after receiving this call the team was informed that John was waiting in the reception area. John entered the meeting room somewhat apprehensively, stating the worker did not show up at the agreed upon site so he took the initiative to find the location of The Family Centre on his own. The mother appeared visibly taken aback by her son's initiative.

The remainder of the session focused on statements made by John regarding the positive changes he had already begun to implement since being released from jail, which included consistent attendance at school, establishing a healthier peer group, living independently in an apartment, and refraining from any criminal activities. The mother, despite her reservations and a fear of once again believing in her son, was able to express interest in rebuilding a relationship that would include trust. Her hopes included the eventual reuniting of John and his two younger sisters and possibly his stepfather.

In an attempt to reinforce John's commitment regarding his new lifestyle, the 2 person reflection team took opposing views of his chances

of success. The team also reflected their support of Carol and John working in a slow moderated way in order to determine the parameters of a new relationship between them. Following the reflection John refrained from making any comments; however, the mother stated that she felt that the team had given her permission to be temporarily ambivalent which she expressed as being a relief to her.

The second session focused on gathering information regarding John's upbringing, which revealed that John had time exclusively with his mother for several years following his parents' divorce. John was able to identify feeling excluded from the family when his mother remarried and eventually gave birth to two more children. He was also able to make a connection between his previous feelings towards his stepfather and his ensuing criminal activities against his stepfather's housing business. John described the family's attempts at disciplining him by taking away privileges as only amplifying his anger towards them, resulting in an ineffective pattern of further restrictions by the parents and subsequent retributions by their son. John described his only motivators in life during this time period revolved around drugs, money, and his new peer group. He stated that he had also become an expert liar and manipulator in order to accomplish his goals. Carol elaborated on the many resources she had attempted to put in place for John, and the level of frustration she felt

role of advocating for her son. The team recommended that Barry, John's stepfather, be invited to the next session in order to gain his perspective on the family dynamics, and that Carol and John discuss who should be in attendance for that session. Following the reflection, it was determined that John would not attend the following session if Barry agreed to join his wife at the next scheduled meeting.

The fourth session was attended by Carol and her husband Barry. The meeting allowed Barry an opportunity to discuss his thoughts and concerns regarding John, which he used to its fullest potential. Barry stated he coped with his stepson by building self-defenses, and described John as "the enemy within." He stressed the importance of family, although he made it clear he was detached from John, and therefore, not prepared to expose his daughters to their brother at this point. Barry clearly did not trust that the changes John was making were genuine. Barry also made statements prophesying catastrophe in John's future if he did not turn his behavior around, yet at the same time Barry would comment on the importance of Carol and her son maintaining a relationship, and he wished John all the best. Carol used this session to really focus on her husband's concerns and recommendations, her only statement throughout this session was that Barry brings her back to reality when she becomes too impatient to move things along.

The reflection team thanked Barry for attending and for making his feelings known and encouraged the couple to continue to talk about the changes John is making since each of them will experience different emotions in response to these changes. Lastly, the team supported the notion that this process should occur at a comfortable pace for everyone involved.

The fifth session was attended by John and his mother. During this session Carol was asked to reiterate to her son the highlights of the last meeting. She stressed Barry's concerns about re-connecting the girls with their brother at this point, as well as noting that Barry believes John can make changes, but he wants to take things slowly. John was able to respond to his mother's comments in a mature manner, by stating that it was up to his mother and Barry to determine when contact could resume with his sisters, and that he was prepared to be patient. Carol also used this opportunity to make her son aware of some of the impact his behavior had on his younger siblings: for example, when John lost the privilege of having his own room he shared a bedroom with his younger sister and since he left home she's been afraid to be alone. On a more positive note, Carol also emphasized that John is now a topic of discussion within the home without shame, and the girls are kept abreast of all of the hard work he is doing to turn his life around. During the session John was also questioned on what had made an impact on him while incarcerated, that has led to his decision

to revamp his lifestyle. He responded by describing living conditions that were so revolting that he vowed to never return. The end of this session focused on assessing the level of contact between mother and son, which to this point had only been phone contact through Carol's work and meetings at therapy. Options were discussed regarding extracurricular activities that Carol and John could mutually agree to and begin to implement, such as meeting for coffee.

During the next few sessions the main intervention for this family was to continue to strive towards realigning the boundary between John and his mother, by consistently increasing the proximity between the two family members. This goal was achieved by ongoing and consistent visits between Carol and John that occurred regardless of John's progress. In addition, these sessions focused on continuing to establish the level of trust between mother and son, as well as to provide an opportunity to resolve any feelings either one had about past events.

Another intervention that was implemented, involved having John's sisters attend one session each. This was possible due to Barry and Carol feeling confident enough in the changes John was making to allow the children to have access to their brother once again. This intervention was necessary in order to provide a forum for the siblings to reconnect, and to begin strengthening the sibling subsystem within the family. During each individual session with his sisters, a discussion was facilitated by the

therapist around resolving past hurts and misunderstandings, including allowing John the opportunity to make statements to his sisters in which he took full responsibility for his past mistakes. Once the three siblings had reconnected through the use of these meetings, the girls were also included on weekend visits with their brother.

John also wanted to make amends with his Maternal Grandfather, from whom he and his peers stole personal items from during a break and enter a year prior. The intervention in this case became having John write his Grandfather an apology letter, as his Grandfather refused to see him face to face. John was able to write the letter after some initial hesitancy, although, due to the Grandfather's ailing health this attempt at reconciling did not take place during the time of this program.

Another intervention centered around assisting John with learning to become more aware of personal warning signs that he was about to revert back to old negative habits. By encouraging John to pay more attention to these warning signs, in addition to having him stratigize possible alternative actions, the hope was he would learn to circumvent his previous patterned behavior.

The reflecting team was able to reinforce the above interventions through their messages of support for the necessary changes. At the same time, the team was cognizant of reflecting comments and raising questions that were new to the family, without being so unusual that the family

rejected the reflection altogether. This was found to be useful in regards to adding alternatives to the family's understanding of their story, and for implementing further change.

After 14 meetings with this family, a termination session was held with Carol and John, to discuss the level of change that had occurred within this family since therapy began. The C & FS worker had planned to attend this session although she regrettably had to cancel just prior to the scheduled meeting. When the mother was asked what changes, if any, had occurred, she elaborated that one of the biggest changes for her was that she could look at her son without shame or embarrassment and that the level of trust between herself and her son had grown immensely. She went on to add that she is now aware that it is not her role to "rescue" her son from his own wrongdoings. She also stated that she has learned to let go of any preconceived notions she had regarding her son's life.

Some of the changes John highlighted included: learning how to break his pattern of becoming "hooked" by maladaptive thoughts; leading a lifestyle that bears little resemblance to his previous way of life; that he feels part of his family again; and that he has discovered what it is to have hope. Both Carol and John were congratulated on their perseverance in regards to maintaining their relationship despite its inherent difficulties. The session ended with a final thanks from Carol to everyone on the team

for all their assistance in helping her to reconnect with her son, and for believing in their family.

This case is perhaps the best example of how a solution-focus can be combined with a structural intervention to elicit change. The focus of therapy in this case was to strengthen the subsystem boundaries within this family. This was achieved by utilizing a solution-focused approach in order to empower this family to bring about the necessary changes. Although John did not return home to live with his family at the point of termination, it is this writer's belief that this family was provided an opportunity to reconnect in a planned methodical manner which benefited all the members of the family.

Data Findings

The mother's initial FAM III profile shows that Communication was the only subscale that fell within the family problem area, it is noteworthy, however, that the Involvement subscale rating was right on the edge of falling within the problematic range. All the remaining scores fell within the normal range of family functioning. At the point of termination the mother's scores were all within the average range. The mother's ratings on Social Desirability and Defensiveness on both the pre- and posttest indicate that her scores are quite reliable.

TABLE 4.3

Case Example C

Measure	Surveyed	Scores	Clinical Interpretation
Family Assessment Measure: *General Scale*	Mother	Pre - 54 Post – 53	Score falls within the average range.
Family Interactions Sub-scale: *Interaction Toward Child*	C & FS worker	Pre – 2.86 Post –2.0	0.86 shift towards the positive end of scale.
Family Interactions Sub-scale: *Child to Caregivers*	C & FS worker	Pre – 3.0 Post – 2.0	1.0 shift towards the positive end of scale.
Family Interactions Sub-scale: *Caregiver to Caregiver*	C & FS worker	Pre – 2.83 Post – 2.25	0.58 shift towards the positive end of scale.
Family Intervention Scale	C & FS worker	Pre – 6.2 Post – 8.2	The average score increased from the range showing a balance between satisfaction and distress to the moderately satisfactory range.
Child's Attitude Toward Mother Scale	Son	Pre - 18.67 Post – 0	Results remained in the absence of a clinically significant problem range.

John's scores on the CAM Scale went from 18.67 on the pretest to a score of 0 on the posttest. Although both scores indicate an absence of a problem, in regards to John's relationship with his mother, it is clear that he identified an improvement in the relationship nonetheless.

The C & FS worker who only attended one session with the family midway through therapy, rated the family on the Family Interactions Sub-Scale as scoring within the mid-range on all three of the categories specified at the point of initial referral, indicating the family had made a positive shift on all three of the categories listed by the point of termination. The worker also rated a significant improvement on the Family Intervention Scale, as the pretest score was rated at 6.2, whereas, the posttest score was 8.2.

Conclusions

In this case the evaluation instruments supported both the family's and the C & FS worker's reports of change. The evaluation results also supported the writer's clinical observations and conclusions about this family and the positive outcomes of therapy.

The mother's pretest scores on the FAM III which indicated that Involvement and Communication were areas of concern for her, can be inferred as meaning that the absence of her son from the family was problematic for this mother, and that the communication levels in the

family at that point were insufficient, again, likely due to John's estrangement from the family. However, at the point of termination the mother's scores on both of these areas showed an improvement which concurs with the mother's comments at the end of therapy.

John's scores on the CAM tests can be interpreted, such that, he did not perceive his relationship with his mother to be problematic at either the beginning or the end of therapy. Nonetheless, by the point of termination his scores indicate that a positive change has occurred in this area, which is also consistent with his statements made in therapy.

The C & F S worker's rating on both scales also corresponded with the statements she made while attending a session midway through the therapeutic process and additional statements made during phone conversations that took place regarding the family's progress. The worker clearly indicated by her scores that she believed this family had made strides towards positive change.

The test results of case example C are an excellent sample of the results of having clinical observations and evaluation tools consistent with each other. The pretest scales effectively measured the level of family functioning before therapy began. After approximately nine months of clinical treatment, these same scales were able to capture the level of positive change that had taken place. Thus, the evaluation instruments appeared to accurately reflect the changes made within this family.

Chapter Five

Implications and Recommendations

This Practicum shows that work in the family reunification field can take various forms with varied outcomes. It is this writer's belief, based on clinical impressions and observations, that the five families who terminated with this project in a planned manner have made positive changes within their respective families. Although the statistical research results did not always coincide with the clinical results, the verbal statements made by the family members and the workers indicated that the families had benefited significantly from the therapy process.

Of the three families who dropped out of the project, the two who received more than one session were both headed by single moms and appeared to bring to therapy a long history of emotional and physical trauma. In addition, these mothers appeared ambivalent in regards to their desire to parent their children on a daily basis, which contributed to serious difficulties in fulfilling their parental role. In both cases, the mothers made a decision to drop out of therapy just as the work came to a critical point about issues of reunifying or remaining together. It would seem that in both these cases the team was shut out of the families' lives in order to enable the mothers' to avoid working on sensitive issues. Hess & Folaron (1991) suggest that in such cases assessments should include a thorough

exploration of the parent's feelings about each child, about parenting in general, and all the options available for each child's permanent care. The goal of therapy would then be to aid these parents in becoming less ambivalent by either assisting them to become more committed to reunification/preservation or clearer about their disinterest in parenting and therefore more able focus towards a more suitable arrangement for their children.

Having families, who are involved with C & FS, referred to The Family Centre of Winnipeg for service, allowed families to feel less threatened by the therapeutic process, as many families indicated that they would not have disclosed their family situation to the same degree if the work had not taken place outside of C & FS environment. Clients also indicated that they experienced the service they received from this program in a positive and validating way, which was often in stark contrast to their experiences with C & FS. In addition, this collaboration between C & FS and The Family Centre provided the caseworkers, who attended sessions along with their families, an opportunity to better understand family dynamics. This increased awareness, for both parties, could have long term benefits beyond the scope of this program.

One of the drawbacks of utilizing the caseworkers as a source of data for the project is that the workers may perceive their ratings on the scales which they were required to complete at the beginning and end of

therapy as a measurement of the quality of their individual work with families. Thus, this may account for the incongruent outcome ratings on a significant number of families who received treatment. Another drawback of using the caseworkers as a source of information about families' functioning is that in many of the cases the workers were often unfamiliar with the full extent of their family's difficulties at the initial point of therapy. In other cases, the worker closed the family's files with C & FS during the course of treatment, resulting in the workers missing the termination session with their families, thus they were not as familiar with the level of change that took place when they were asked to complete the research scales. Many of the families who were seen within this project, outside of the eight families who received service as a result of this Practicum, had their caseworkers change over the course of therapy, in some cases several times, which makes the evaluation of the program based on the workers' ratings highly questionable.

One of the implications of utilizing a reflecting team format in this manner is that the team would support the interventions being implemented through the messages they would give through the phone calls during the sessions, as well as during the reflection phase of treatment, which would serve to further highlight the desired direction of change. Another implication of the use of a reflecting team is that the team raised questions and recommendations that the author did not or could not address during

meetings with families, which allowed topics that might have otherwise gone unaddressed to be brought out in the open. In addition, the team added new ideas and explanations to the clients' situations which allowed the families to have a different perspective on their problems which was often a validating and empowering experience. Lastly, the ability to work within a team format was found to be a positive experience for the writer, as the team members would share their clinical expertise during and after the sessions which was an informative and exciting learning opportunity.

It is this writer's belief that the expanded viewpoint offered by the integration of a structural and solution-focused approach offers a greater potential for change for families wishing to reunify. The combined perspectives of both clinical approaches provides more therapeutic interventions for problem solving. Family reunification can take many forms, even in those families in which the full reentry of the child into the family is not feasible, or where lengthy separations have occurred, this approach is still important in reconnecting children with their families by: strengthening and enhancing family ties; assisting children to gain a sense of support and nurturance; assisting parents with the child's developmental stage; having unresolved feelings addressed and sorted out; and parental roles can become clarified and strengthened.

Chapter Six

Conclusions

EVALUATION OF SKILL DEVELOPMENT AS A THERAPIST

There are a number of areas which this writer clearly developed as a result of this Practicum experience. One of the most notable changes has been the increased clarity of thought regarding assessing family structure. Prior to this experience there had been little opportunity to develop skills in this area. However, as a result of this Practicum, family structure can now be clearly identified, as well as stating what evidence supports the view.

The utilization of a specific model has consolidated the foundation of past learning and experiences, enabling a new level of understanding and skill development to occur. This is especially relevant in regards to implementing a solution-focused approach, in which the author had some previous experience. As a result of the increased exposure to this approach, the writer was enabled to systematically ask questions in a respectful manner that promoted change.

This Practicum also provided an opportunity for the writer to learn how to interpret the research results, including the ability to analyze the effectiveness of the evaluation procedures implemented.

During the period of this Practicum the author gained further clinical

skills from working alongside a team of experienced clinicians, whose insights and expertise were extremely helpful in shaping the writer's abilities as a therapist. The team provided clinical assistance on a number of occasions through phone calls during sessions. These calls took place when the writer was either getting off track with clients, or to ask specific questions that were not yet addressed, or simply to highlight their impressions behind the mirror. The team also provided clinical feedback following each session, as well as during weekly team meetings.

It is this writer's belief that skills were also developed in regards to becoming a more effective collaborator with caseworkers, as this Practicum required numerous phone consultations, planning with workers during sessions, and in one case a systems meeting between project staff and C & FS.

Finally, as a result of working with families with diverse issues and experiences, ranging from, cultural diversity, family form, social class and mental health issues, a new level of understanding has taken place regarding the various challenges facing both families and clinicians alike.

CONCLUSIONS

In order to provide a broad range of clinical experiences, treatment was provided to blended, single parent, intact and co-parent families. Therapy was provided to families that identified problems with; parent-

adolescent conflict, physical and emotional abuse, neglect, delinquency, truancy, deteriorating or poor school performance, running away, depression, criminal activities, incarceration, and substance abuse. Treatment was also provided to families wishing to reunify, or to remain living together, as well as for those families who chose to live apart but who wished to achieve their optimal level of reconnection.

This Practicum provided family therapy services to eight families over the course of a ten month period. Treatment for three of the families was considered unsuccessful since they dropped out of therapy. The remaining five families stated that they had made significant progress towards achieving/reaching their goals. The maximum duration for the therapeutic process was fifteen sessions which occurred with two of the families. The briefest was only one session.

Overall, the Practicum was a positive experience for both the writer and the families who were provided service. A key element was the collaboration between C & FS and The Family Centre of Winnipeg in providing a neutral and supportive environment for families. In addition, utilizing a solution-focused approach is an effective model of therapy that often exposes people's resources, solutions and strengths, that can promote rapid change. Furthermore, this model is often perceived by clients as being a very respectful and validating experience.

The research results of this Practicum show that the intervention was somewhat effective with the individual families who received service in the program. It should be noted that these findings cannot be generalized to the population of families whom the Reunification Program serves as the intervention was applied by the same clinician. The families discussed in this Practicum were a random sample from the population of selected cases eligible for reunification.

In conclusion, it has become clear that the structural model can be integrated with a solution-focus. Each model of therapy exerts an influence upon the other. Briefly summarized, the structural model was used to make an assessment of the family structures blocking the resolution of the problem. Solution-focused therapy is based on the respectful assumption that clients have inner resources to construct highly individualized and uniquely effective solutions to the problems that bring them to therapy. Solution-focused therapists ask questions in therapy which evoke resources, solutions and abilities. In conclusion, it is this writer's belief that the integration of both models provides for a more effective delivery of service.

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APPENDICES

APPENDIX A

FAM-III: GENERAL SCALE

Family	Task Accomplishment		Role Performance		Communication		Affective Expression		Involvement		Control		Values & Norms		Overall Rating		Social Desirability		Defensiveness	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
A Mother	4	6	9	9	9	7	5	5	5	5	6	7	5	9	56	58	12	9	15	12
Father	5	N/A	4	N/A	4	N/A	5	N/A	4	N/A	4	N/A	7	N/A	49	N/A	11	N/A	11	N/A
B Mother	9	2	3	3	9	3	9	2	3	6	4	3	7	2	37	37	11	7	13	13
Father	2	4	2	3	2	3	8	2	1	6	4	3	3	3	26	34	9	8	14	13
C Mother	6	7	7	6	7	5	6	6	7	6	4	5	5	5	54	53	5	7	8	8
D Mother	7	4	6	5	6	5	6	4	6	2	5	5	4	3	53	46	10	9	8	7
Father	6	5	8	8	7	8	9	10	2	5	4	6	8	7	54	60	9	2	11	9
E Mother	6	5	7	4	7	5	4	5	4	3	6	4	6	5	54	47	6	6	8	8
F Mother	7	N/A	9	N/A	9	N/A	9	N/A	6	N/A	7	N/A	5	N/A	61	N/A	7	N/A	8	N/A
G Mother	9	N/A	7	N/A	9	N/A	6	N/A	6	N/A	7	N/A	7	N/A	61	N/A	2	N/A	7	N/A
H Mother	7	N/A	10	N/A	7	N/A	6	N/A	8	N/A	8	N/A	6	N/A	61	N/A	7	N/A	12	N/A

APPENDIX B

CHILD'S ATTITUDE TOWARD MOTHER (CAM)

Family	Scale Completed By:	Pretest Score	Posttest Score
A	Daughter	54.67	28.67
B	Daughter	2.67	72.0
C	Son	18.67	0
D	Son	N/A	N/A
E	Daughter Son	3.33 2	4.67 N/A
F	Daughter	18	N/A
G	Daughter Son	16.67 15.28	N/A N/A
H	Daughter Son	8.67 16.67	N/A N/A

APPENDIX C

FAMILY INTERACTIONS SUB-SCALE

[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
A	C & FS Worker	*Mother* Pre – 3.21 Post – 3.71 *Father* Pre – 3.71 Post – 3.93	*Mother* Pre – 3.33 Post – 3.83 *Father* Pre – 4.0 Post – 4.5	*Mother* Pre – 3.17 Post – 3.67 *Father* Pre – 3.5 Post – 4.0
[illegible]	C & FS Worker	*Mother* [illegible] *Father* [illegible]	*Mother* [illegible] *Father* [illegible]	*Mother* [illegible] *Father* [illegible]
C	C & FS Worker	*Mother* Pre – 2.86 Post – 2.0	*Mother* Pre – 3.0 Post – 2.0	*Mother* Pre – 2.83 Post – 2.25
[illegible]	C & FS Worker	*Mother* [illegible] *Father* Pre – N/A Post – N/A	*Mother* [illegible] *Father* Pre – N/A Post – N/A	*Mother* [illegible] *Father* Pre – N/A Post – N/A
E	C & FS Worker	*Mother* Pre – 2.64 Post – 3.25	*Mother* Pre – 2.64 Post – 3.25	*Mother* Pre – 2.64 Post – 3.25
[illegible]	C & FS Worker	*Mother* [illegible]	*Mother* [illegible]	*Mother* Pre – N/A Post – N/A [illegible]
G	C & FS Worker	*Mother* Pre – 3.71 Post – 4.29	*Mother* Pre – 4.33 Post – 4.83	*Mother* Pre – 5.0 Post – 4.83
[illegible]	C & FS Worker	*Mother* [illegible]	*Mother* [illegible]	*Mother* Pre – N/A Post – N/A

APPENDIX D

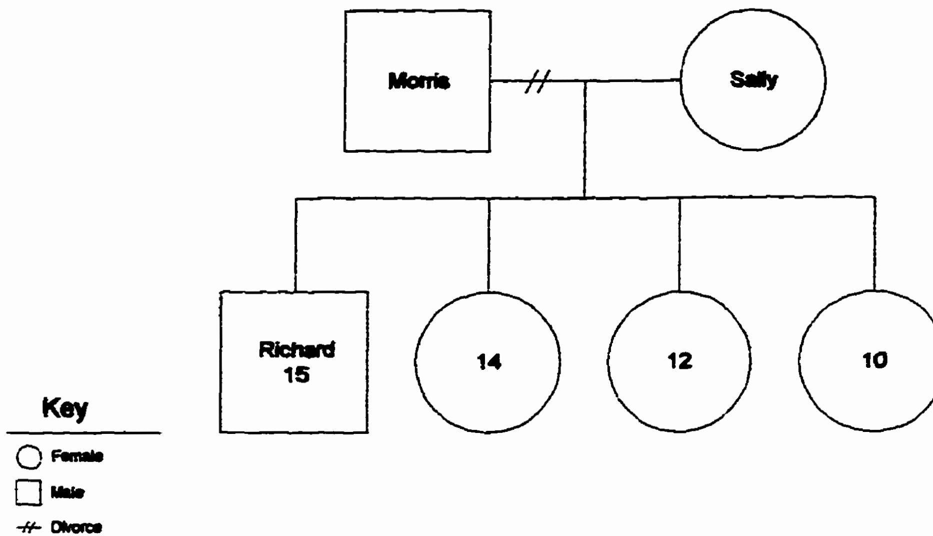
FAMILY INTERVENTION SCALE

Family	Scale Completed By:	Pretest Score	Posttest Score
A	C & FS Worker	5.6	4.6
B	C & FS Worker	7.2	6.6
C	C & FS Worker	6.2	8.2
D	C & FS Worker	6.6	8.4
E	C & FS Worker	5.2	7.0
F	C & FS Worker	6.8	N/A
G	C & FS Worker	5.0	4.8
H	C & FS Worker	5.6	N/A

APPENDIX E

FAMILY BIOGRAPHIES

FAMILY D

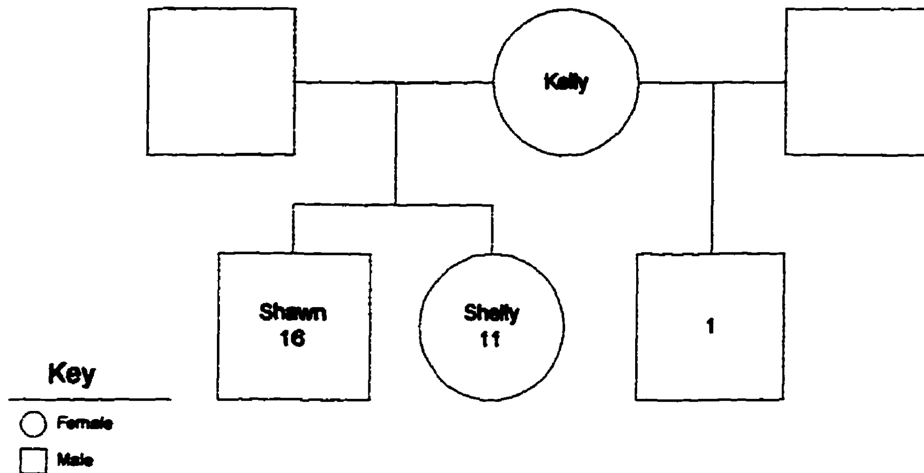


Family D is a divorced co-parent family, who were referred to the Reunification Program in order to strengthen the parental subsystem, thereby enabling the parents' ability to consistently parent their oldest child Richard. The parents were seen for a total of six sessions. Within the six sessions, the parents were seen separately for one session each at the beginning of therapy, and a seventh session was held with the mother and Richard. Richard has engaged in various criminal activities revolving around his drug usage, which has lead to him dropping out of school, running away from both of his parents' homes and being sentenced to serve time in the Manitoba Youth Centre during the time therapy was being offered to the family.

FAMILY D (Continued)

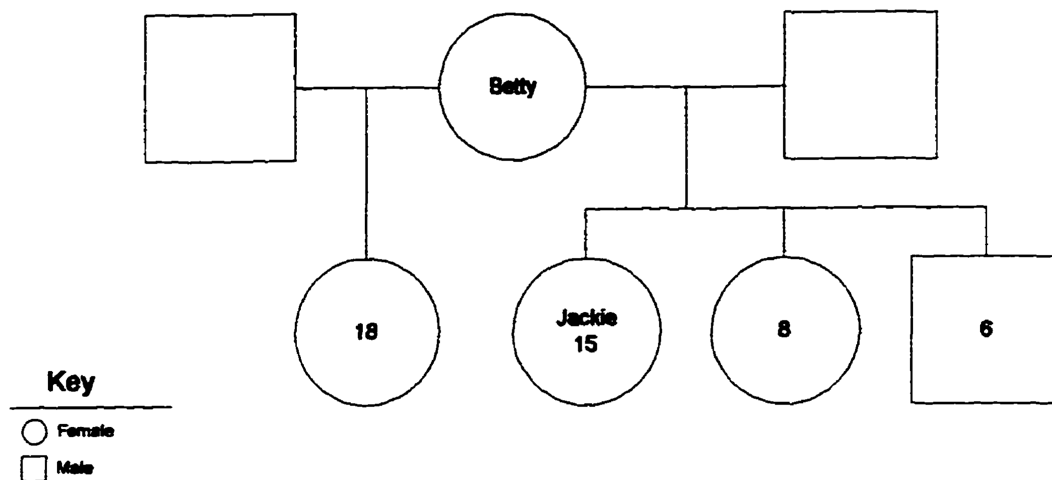
The intervention in this case was to assist the parents in giving their son consistent messages regarding their expectations of him, and for the parents to be united on their plan for their son upon his release from MYC, despite their different parenting styles. The parents were able to make a positive shift towards more consistently parenting their son by the point of termination, which included a mutually agreed upon plan for their son upon his release from incarceration.

FAMILY E



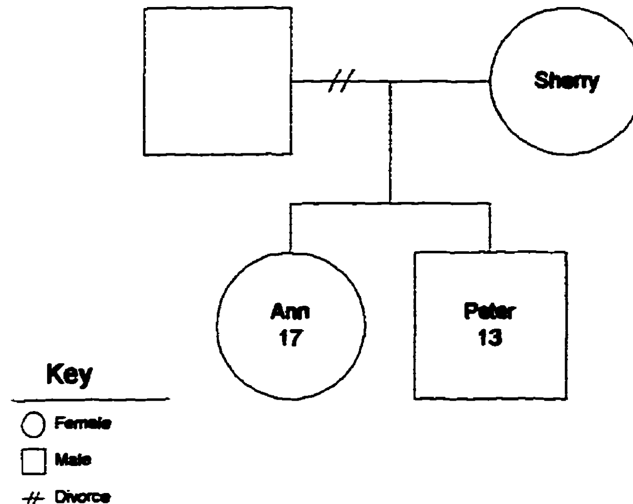
Family E is a single parent family, who were referred to the project in order to reunify the two oldest children with their mother. The children had been living with their maternal grandparents for the past three years as their mother was unable to provide a stable living environment for her children. The family was seen for a total of five sessions and in addition, the mother was seen individually for two sessions. The focus of the intervention was to assess the readiness of each of the family members to be reunified and to address any unresolved issues that the family members brought to therapy. The intervention also included elevating the mother's hierarchy within the family in order for her to be seen by her children as being an authority figure. At the point of termination, the children had been successfully reunified with their mother.

FAMILY F



Family F is a single parent intact family, who were referred to the project in order for the children, especially Jackie, to remain living in the home. The caseworker also believed that by referring this family to our project it would give the family an opportunity to discuss past unresolved issues and to find new ways to resolve conflict. The family was only seen for one session, as shortly after therapy began the mother started working two jobs and was unable to attend further sessions.

FAMILY G



Family G is a divorced family whereby the children live in separate foster homes. The family was seen for a total of five sessions, in addition, the mother was also seen individually for three sessions. The mother separated from the children's father in 1993 due to alleged physical and verbal abuse. Sherry had custody of the children for one year prior to them being placed in foster care. The children were taken into care due to their extreme sibling rivalry and aggressive behavior towards one another, as well as towards their mother. The focus of the intervention was to assess the viability of Peter returning home, as Ann stated she wished to remain in care. The mother expressed a desire for the three of them to resolve their past hurts, however, she remained ambivalent in regards to her desire to have Peter return home. The mother was seen individually in an attempt to deal with some of her unresolved issues regarding her marriage, her role as a parent, and her feelings towards her children.

FAMILY G (Continued)

In addition, these sessions attempted to elevate the mother's position within the family in order for her children to view their mother as a competent and capable parent. During the family sessions solution-focused questions were utilized to identify and highlight any positive steps the family members were attempting during visits, and to explore each of the family members' goals. The mother terminated the sessions prematurely when the reflection team commented that the mother's approach towards her children may be misinterpreted by the kids as disinterest, and challenged the mother to focus on the next steps needed in order to move along the process of each of them reconnecting.