SOLUTION-FOCUSED PRACTICE
WITHIN A CASE-MANAGEMENT MODEL:
GROUP AND FAMILY WORK WITH ADOLESCENT FAMILIES
IN MENTAL HEALTH

By

Susan Kytaychuk

A Practicum Submitted to
the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements for the Degree of

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Faculty of Social Work
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THE UNIVERSITY OF MANITOBA

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ABSTRACT

Social work interventions with adolescent families in a mental health setting require a broad-based set of skills guided by research and theory. Intervention modalities in this practicum experience cover case management, family therapy and group work. Case management interventions provided service co-ordination of essential services to families in an adolescent mental health short-term outpatient hospital setting. Solution-focused therapy guided family work and its strengths and limits within adolescent mental health population are examined. A psycho-educational group intervention for parents provided an adjunct intervention to treatment in a multi-disciplinary environment. Evaluation of this practicum included the FAM III, self-report measures, the CSQ-8, and clinical observations. Solution-focused interventions showed a reported average of 20%-80 % improvement in family therapy. Parents found the psychoeducational group helped them deal more effectively with their adolescent, and would definitely recommend the group to other parents. Implications of the practicum experience to social work are explored.

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CHAPTER ONE - INTRODUCTION

The social worker's role of case manager in a mental health setting is broad and yet unique in a multi-disciplinary team. Providing family and group counselling are main functions that require experience, mentoring and knowledge to develop a skill base. This practicum integrates significant functions of a social work intervention in adolescent mental health using three different modalities: solution-focused family counselling, psychoeducational group counselling and case management.

Rationale

Solution-focused theory was selected as one theory on which to build since some of its basic assumptions enhance work with families in mental health. Clients facing mental health issues can feel defeated by their illness or the stigma that accompanies it. In working with the mental health client population, solution-focused theory provides a complement to an overwhelming problem focus by working with client resources from a competence-based approach. Using a solution-focused approach, the therapist acknowledges the strengths and past successes the client brings to the session. The model has a future focus in creating goals and provides a therapeutic direction that is conducive for a short-term setting. The solution- focused approach is complementary to social work practice that helps clients in complex situations improve coping abilities (Kirst-Ashman & Hull, 1999).

A second theoretical perspective utilized in this practicum was the use of psychoeducation. Psychoeducation is advantageous to families who are dealing with a member who is mentally ill (Fristad, Gavazzi, Mackinaw-Koons, 2003; Dixon, McFarlane, Lefley, Lucksted, Cohen, Falloon, Mueser, Miklowitz, Solomon,

Sondheimer, 2001). Knowledge and understanding can bring stability to an atmosphere of chaos. A parenting group is valuable to families as they learn they are not so isolated or alone. A secondary advantage of the use of psychoeducation was that it helps parents to differentiate between normal development issues and symptoms, which are related to illness. Helping parents to function better is in line with social work goals in that it targets the family environment for change rather than the adolescent and his or her struggles.

Connecting theory to practice to guide interventions is consistent with social work practice (Kirst-Ashman & Hull, 1999). Working with any model will require specific knowledge about a given population, especially in the field of mental health where people experience a broad range of illnesses and varying degrees of severity. For this practicum, the psychoeducational group experience enhanced solution-focused family and case management interventions by further building my knowledge about the adolescent mental health population.

<div align="center">Objectives</div>

Working in a teaching hospital environment provided many opportunities for the student. The student set objectives at the beginning of the practicum in order to maximize learning and determine the scope of this practicum. The five main learning objectives were:

1. Increase knowledge and experience with solution-focused interventions.
2. Develop assessment and intervention skills with adolescent families in a mental health setting.

3. Gain experience in developing and co-facilitating a psychoeducational group for parents whose adolescents are dealing with mental health concerns.

4. To learn how to make use of clinical supervision and client feedback to inform practice.

5. To learn the role of a social worker in a multidisciplinary team in a mental health setting.

CHAPTER TWO – LITERATURE REVIEW

Introduction

This chapter reviews literature pertaining to the different types of social work

applications used with the adolescent mental health and family client population. The

first section explores psychoeducational theory, a well-supported approach with the adult

mental health client population that is emerging with adolescent families. The second

component of this review explores the different models and interventions of case

management. Case management is not a theory, yet this valuable intervention is used in

multi-disciplinary practice.

The final component of the review will examine solution-focused theory. At the

basis of solution-focused theory is a focus of working with the strengths and capabilities

of clients. This approach is well suited for adolescents and their families in mental health.

A survey of solution-focused principles, application and support is provided as it pertains

to the adolescent population.

Mental Health

There are many definitions of mental health and mental illness. Fellin (1996)

refers to the following terms found in describing mental illness: "mental disease, mental

disorders, diseases of the brain, mental disabilities, emotional problems, developmental

disorders, personality disorders, psychological or psychiatric disabilities, and psychiatric

problems" (p. 18). Complications can arise in describing mental illness since definitions

can be very broad (e.g. mental health vs. mental illness) or very specific such as disorders

listed in the Diagnostic and Statistical Manual of Mental Disorders (Fellin, 1996).

Disorders are classified in terms of mild, moderate, severe, in partial or full remission

(American Psychological Association, 2000). "Dual diagnosis" or comorbidity refers to two disorders that occur at the same time such as a psychiatric disorder and alcohol/drug dependency.

Controversy exists in the field as to whether mental illness should be grouped with the term mental disability (Fellin, 1996). Dealing with clients who have mental disabilities is out of the scope of this practicum; however, a comparison between the two terms, mental illness and mental disability, illustrates how mental illness is less permanent. Illness refers to ill health that one falls in and out of and can recover from. Disability refers to mental or physical permanency. People with developmental disabilities (formerly referred to as mental retardation) remain at a low level of intellectual functioning and quite often do not experience mental illness, although some may experience both. In terms of mental illness, there are various levels of severity that result in different levels of functioning for clients.

Relapse of illness is a reality for many. In regards to medication treatment for manic depression, 40% of patients will have a relapse of mania or depression within a year (Silverstone & Romans-Clarkson, 1989). For people who are hospitalized for schizophrenia, 50% will return within 12 months, and in the U.S. treatment costs are nearly $2.3 billion per year (Weiden & Olfson, 1995).

Research is being conducted on the early prevention of mental illness in youth and its progression in adulthood. Currently research is aimed at lowering the impact of illnesses but more research is needed to see if high-risk disorders can be prevented from developing altogether by early detection and treatment in youth (Forsyth, 2004).

Mental illness in teenagers and children can differ from that in adults. Symptoms of emerging schizophrenia, bipolar disorders and depression can be difficult to identify in youth even though the diagnosis is the same as for adults. Problems that hinder diagnosis are: 1) young children cannot verbalize the confusion or fear associated with schizophrenia; 2) symptoms found in bi-polar illness that consist of irregular sleep patterns, moodiness, and impulsivity can be hard to identify since they are also characteristics of adolescence; and, 3) youth may express depression showing symptoms of irritability more than verbal expression of feelings (Taylor, 1998).

Barriers exist in the diagnosis of youth with a mental illness. Symptoms can be easily confused with the turbulence of adolescence. Parents may not seek help in the hope that symptoms will change when their youth gets older (Taylor, 1998). Young individuals may be unaware of what is going on and some may turn to drugs or alcohol to deal with symptoms (Keefler, 2001; Taylor, 1998). Complications in diagnosing mood occurs as disorders can "result from biological causes...medical or physical illness, trauma, environmental adjustment problems, and substance abuse" (Taylor, 1998, p. 319). Even when parents take their adolescent to see a psychiatrist, the psychiatrist may think it is too early for a diagnosis; for example, some doctors have preferred to take a more cautious approach with young individuals who met the criteria for schizophrenia and who have had their first episodes of psychosis (Keefler, 2001).

Families and Mental Health

Although much attention is placed on the individual who struggles with the illness, the family unit is affected as well. Challenges for the family can be identified in three areas: 1) *situational stress* - stresses related to communicating with or care-giving

for a mentally ill individual; 2) *societal stress* - stress involving rejection or isolation from the community; 3) *iatrogenic stress* - problems associated with accessing services, such as a lack of resources, or inadequate service or information (Lefley, 1997).

When mental illness occurs in one member, the whole family is subject to stress. The caretaker burden of parents in caring for a child with a mood disorder can include disruptions in family schedules when the child is in and out of crisis situations (Goldberg-Arnold, Fristad, & Gavazzi, 1999). Treatment demands (dealing with social agencies and providers, residential placement; and treatment costs) and balancing the needs of other family members including siblings are experienced (Lefley, 1996). When mental illness occurs in one member, the whole family is subject to stress. The following describes how families who have a child or adolescent with schizophrenia are psychologically affected (Hatfield, 1978):

1. All members experience emotional suffering.

2. Family members can blame each for the behaviour problems (siblings may blame parents, parents may blame each other).

3. Siblings tend to experience difficulties with friendships.

4. The investment of time to address the illness takes away from family social and recreational time.

Children who have a brother or sister with a mental illness can experience tension and resentment about parental inattention, guilt about the sibling's illness, and loss related to the family's social life (Lefley, 1996).

Needs in the Family

Families are seeking knowledge about the illness and medication, ways to help the client to change, realistic expectations, and how to deal with crisis situations (Hatfield, 1983). Families want to be reassured that they did not cause the illness, nor are to blame for it (Garson, 1986). Families want help in how to deal with substance abuse, aggressive behaviour, suicide prevention and creating positive family relationships (Mermier, 1993).

When an individual is unable to notice he or she is experiencing symptoms of illness, family members are able to give a more accurate account of symptoms than the patient; since symptoms could be hidden from health professionals but are more difficult to hide from the family (Keefler, 2001). If the individual refuses treatment, there is a risk the illness can get worse and stress will increase for the family. Some people have resisted help from families and ended up isolated and even homeless (Keefler, 2001).

The family will need to grieve over the loss of the individual to mental illness especially if the illness becomes chronic (Lefley, 1996; Miller, 1996). The grieving process can be difficult if the individual or family denies its existence. This process is necessary for adapting to the changes (Keefler, 2001; Miller, 1996). Miller (1996) describes a model of intervention for families that includes four tasks: 1) identifying individual losses; 2) expression of affect, 3) adjusting to the loss; and, 4) making a new connection with the relative who is ill. The work is similar to grief therapy; however, families are not grieving the death of an individual but an "idealized internal image" and the previous personality of their ill family member (Miller, 1996, p.634). From this point family members are able to gain realistic expectations and acknowledge healthy aspects

of the ill person. Miller also suggested grief treatment for families after a psychoeducational or support group.

Family plays an important role in the recovery process. Keefler (2001) argues that family interventions should be a main source of treatment for the chronically ill rather an option, since: a) families are the "assessors, monitors, crisis managers, and advocates...and have a future with the individual (p. 203); and, b) families are the first to notice signs of relapse. Family interventions also have an influence on medication compliance (Azrin & Teichner, 1998).

Psychoeducation and Mental Health

A psychoeducational group is one component of a treatment plan that may contain counselling, medication and other types of rehabilitation (Walsh, 2000). Psychoeducational groups play an important role in mental health. In psychoeducational family approaches Milkowitz & Hooley (1998) postulated:

1. The family is challenged by the psychiatric disorder.

2. During similar episodes families become unbalanced which negatively impacts the patient's improvement. Communication and problem solving abilities are thwarted.

3. Treatment involves helping families gain stability.

Psychoeducational treatment groups are aimed at meeting the needs of clients by presenting educational material that is specific to their area of concern. Treatment groups can combine both education and support components. Characteristics can differ between groups in size, session length, duration or having open or closed group membership. Groups can be as short as one information session or continue for over a year. Content

can cover many topics and is based upon the needs of the clients. Meetings generally contain a moderate to high level of structure. Group activities are comprised of educational material, task reviews, role-plays or simulations and discussions (Toseland & Rivas, 1998).

In order to meet the needs of families dealing with a member who is mentally ill, Hatfield (1983) advised the following topics should be included in psychoeducational groups: 1) information about mental illness; 2) interventions; 3) how illness affects the family; 4) long-term preparations for the ill family member; and 5) dealing with crisis.

Psychoeducational approaches use a collaborative instead of a blaming approach with families, recognizing that the illness can bring increased stress and isolation that can negatively impacts family environments, which in turn can negatively affect the illness (Nichols & Schwartz, 2001). Since families are the main caretakers of their ill members, they need to be provided and empowered with information, resources and support to deal with the patient so that reduced tension and better ways of coping result (Milkowitz & Hooley, 1998).

Milkowitz & Hooley (1998) discussed the complexities in developing a family psychoeducational treatment program. Depending on the illness, variations in a specific disorder can exist. There may also be diversity within a homogenous population with the same diagnosis; for example, some bipolar patients can cycle quickly while others may have a dual diagnosis of alcohol abuse, or a personality disorder. Treatment issues can vary; some families may need to adjust to the first major affective episode while others deal with a family member who has had many episodes.

Expressed Emotion

Expressed emotion in families refers to the responses of family members towards the individual who is ill. High emotional reactivity can result from the tension in dealing with the illness, but the family should not be blamed for etiology. A high level of expressed emotion indicates "hostile and critical attitudes and/or emotional over-involvement" (Goldberg-Arnold et al. 1999, p. 412).

Expressed emotion has been associated with poorer outcomes in studies of children with mood disorders (Asarnow, Goldstein, Thompson, & Guthrie, 1993), eating disorders (Szmuker, Eisler, Russell & Dare, 1985) and unipolar depression (Hooley, Orley & Teasdale, 1986). Careful consideration needs to be given to the usefulness of the expressed emotion concept as it implies blaming families for the illness (Dixon et al., 2001). The importance of the expressed emotion concept is supported, as it led to the development of education for families about mental illness and treatments that provide a more supportive environment for the client and his or her family (Dixon et al., 2001; Nichols & MacFarlane, 2002).

Adolescent Development

Psychoeducational programs need to provide education on normal adolescent development in order to help parents distinguish normal development issues from mental health issues. Transitions into new stages are especially threatening for adolescents and families facing a mental health crisis. Adolescence can be described as a developmental stage where teenagers move away from childhood and face new beginnings and challenges of preparing towards adulthood. Symptoms can emerge and impede development for families at this time (Miccuci, 1998).

Adolescent development can be an important part of psychoeducation in work with families in which youth are dealing with mental health issues. Miccuci (1998) defied the myth that adolescence is a natural phase of turbulence. He considered misinterpretations of development issues problematic: symptoms may be misinterpreted for normalcy, or conversely, developmental issues can be mistaken for pathology; youth can internalize negative images as part of their identity, or parents can thwart their child's growth by pre-empting demands for maturity. Unnecessary parent-child conflict and stress can result from unrealistic expectations of teenagers.

In dealing with adolescents who face mental health issues it is important to distinguish normal development issues from mental health concerns. The American Academy of Child & Adolescent Psychiatry (AACAP) (1997) divides the adolescent stage into two phases: 1) early and middle adolescence, and 2) the later years and beyond. Although each teenager is an individual, the developmental challenges each one faces are considered expected adjustments to adolescence (AACAP, 1997). The issues of the two stages are described by the AACAP in Table 1:

Table 1: Adolescent Stages of Development

	Early & Middle Adolescent Years	Late Adolescent Years & Beyond
Increasing Independ-ence	• Struggle with sense of identity • Feeling awkward or strange about one's self and one's body • Focus on self: alternating between high expectations and poor self-concept • Interests and clothing style influenced by peer group • moodiness • Improved ability to use speech to express one's self • Realization that parents are not prefect; identification of their faults • Less overt affection shown to parents, with occasional rudeness • Complaints that parents interfere with independence • Tendency to return to childish behaviour, particularly when stressed	• Increased independent functioning • Firmer and more cohesive sense of identity • Examination of inner experiences • Ability to think ideas through • Conflict with parents begins to decrease • Increased ability for delayed gratification and compromise • Increased emotional stability • Increased concern for others • Increased self-reliance • Peer relationships remain important and take an appropriate place among other interests
Future Interests & Cognitive Development	• Mostly interested in present, limited thought of future • Intellectual interests expand and gain in importance • Greater ability to do work (physical, mental, emotional)	• Increased concern for the future • Work habits become more defined • More importance is placed in one's role in life
Sexuality	• Increased interest in the opposite sex • Movement towards heterosexuality with fears of homosexuality • Frequently changing relationships • Worries about being normal	• Feelings of love and passion • Development of more serious relationships • Firmer sense of sexual identity
Morals, Values & Self-Direction	• Rule and limit testing • Capacity for abstract thought • Development of ideals and selection of role models • More consistent evidence of conscience • Experimentation with sex and drugs (cigarettes, alcohol, and marijuana)	• Greater capacity for setting goals • Interest in moral reasoning • Capacity to use insight • Increased emphasis on personal dignity & self-esteem • Social & cultural traditions regain some of their previous importance

American Academy of Child & Adolescent Psychiatry. (1997). Normal adolescent development: Middle school and early high school years. *Facts for Families and Other Resources, No. 57*. Retrieved September 15, 2003, from http://www.aacap.org/ publications/ factsfam/ develop2.html

American Academy of Child & Adolescent Psychiatry. (1997). Normal adolescent development: Late high school years and beyond. *Facts for Families and Other Resources*,No. 58.Retrieved September 15, 2001, http: //www.aacap.org /publications/factsfam/develop2.html

Parents are seeking answers in how to deal with difficult adolescent behaviours. Miccuci (1998) describes these behaviours on a continuum in terms of difficulty in Table 2.

Table 2

Continuum of Acting-Out Behaviours

Mild	Moderate	Severe
• test limits by violating rules or showing verbal disrespect to parents • many instances of compliant and pro-social behaviour • no violence against property or people • problem behaviour is exception not rule	• more persistent pattern of defiance • might be regular users of alcohol or drugs • might be engaging in promiscuous sexual activity • marginal school performance • frequent arguments with family members, involving cursing, threats, fits of temper • no violence to anyone in the home • legal involvement, if any, has been minimal	• possibility of serious danger either to the adolescent or to other family members • pattern of running away or staying out overnight • daily use of drugs and/or multiple drug use • problems with the law • theft from the family • physical violence • truancy, failure, and/or serious behaviour problems at school

(Miccuci, 1998, p. 175)

The degree of severity can determine the intervention. A common reaction of parents is to gain control through increased and more severe consequences. In fact, increased parental authority without attachment to the youth can result in the youth turning to her/his peer group rather than the parents for support. In *mild or moderate* instances, supporting the parental hierarchy and authority to parents can backfire especially if this is done at the expense of the relationship with the adolescent. Miccuci explained that addressing the problem behaviour only encourages compliance towards the parents at the expense of developing the adolescent's ability to regulate and monitor his

or her own behaviour. Furthermore, feelings that led to the behaviour are left unacknowledged and opportunities for growth are missed.

In dealing with *severe* behaviour problems, the parents' or teenager's safety can be at risk. Miccuci (1998) advised parental power is to be initially restored by shifting focus off controlling the youth, and then towards a focus on what the parents need to do to restore control over their own lives. Threats of violence in the home can be addressed by calling the police if necessary; if items are stolen, the youth's items can be confiscated. Another example is that parents may need to reconnect to relationships from which they may have become isolated. The second and overlapping phase involves rebuilding the relationship with the teenager. With severe behaviour problems an increase in control and understanding are both needed. Miccuci's maxim in family work involving adolescents requires the therapist to be concerned about how parents are making decisions, more so than what the decisions are.

In dealing with problematic behaviours the family counsellor needs to be cautious of lurking mental illness. Behaviour problems can camouflage psychiatric disorders: a boy could have a sleep disorder and problems with curfew and staying up late; some teens may lose weight and turn to drugs to deal with depression, or a binge of disruptive behaviours can stem from bipolar disorder (Miccuci, 1998).

Psychoeducational Outcome Research

Psychoeducation has developed as a response to lowering the rate of expressed emotion in families who are dealing with a member with a mental illness (Fristad, Gavazzi, Mackinaw-Koons, 2003) . In a review in the effectiveness of treatment, support for family psychoeducation for adults with schizophrenia has been established as an

evidenced-based practice that lowers relapse rates (Dixon et al., 2001). Family psychoeducation for youth with mood disorders is not yet clearly supported by the research (Fristad et al., 2003).

Preliminary research in the area of psychoeducation for youth with mood disorders examined the impact of one-time only psyhoeducational session (Brent, Poling, McKain, & Baugher, 1993). This study that measured a two-hour psychoeducational program on depression in an outpatient program found significant improvement of parental knowledge and attitudes. Adolescents were suicidal, affectively ill (depressed) and had a diagnosis of major depression, dysthymia, bipolar I or II, cyclothymic or atypical affective disorders. Sixty-two parents attended the two-hour seminar. The authors developed a questionnaire to measure knowledge and attitudes before and after the session. Qualitative research sought subjective experiences; over 97% of parents found the session useful, clearly presented, and thought it had increased their knowledge. The authors found a need for more attention on areas such as the course of depression, its association to normal development and family influence on the illness.

In a second study, a psychoeducational workshop for parents of children and adolescents (ages 10-18) with mood disorders (major depression, bipolar, or dysthymic disorders) yielded positive results (Fristad, Arnett, & Gavazzi, 1998). A clinical psychologist presented material on mood disorders covering symptoms, etiology, course, prognosis, treatment, and family influence on outcome. Emphasis was placed on not blaming the family for the cause of the illness. This study is distinctive in that the authors claim it is the first to measure expressed emotion and knowledge in the area of child and adolescent inpatient treatment. Measurements were administered before the 90-minute

session and at a 4-month follow-up. Results showed a significant improvement in understanding mood disorders, improving positive interactions and reducing negative interactions. Generally fathers and stepfathers improved the most as mothers may have had fewer areas to improve upon. The authors postulated a positive impact on parenting as the gap between mothers and fathers on knowledge and expressional level narrowed. Findings were limited as families may have been part of many other interventions such as pharmacotherapy or counselling.

Recently, Fristad, Goldberg-Arnold, & Gavazzi (2003) have made a progressive step into the area of well-controlled studies by comparing multi-family psychoeducational treatment group for children (ages 8-11) with mood disorders to a wait-list group. Parents in the treatment group were reported to have: 1) a significant increase in parental knowledge of mood disorders; and, 2) parental gain in positive interaction ratings. Children were reported to have perceived: 1) a significant improvement in social support of parents; and 2) a higher level of social support of peers than the wait-list group, although the result is not statistically significant. This study consisted of 35 children and 47 parents. Treatment groups consisted of six monthly meetings of highly structured sessions that included information on mood symptoms and treatment, healthy and unhealthy family reactions, resources and advocacy in schools and the mental health system, and the use of role-plays for skill building. Children began and ended the session with the parenting group. The children's group component consisted of addressing questions on medication, role-plays to building social skills, anger management, and peer support. The study was limited by the small sample size and narrow demographics that consisted primarily of working class participants.

The efficacy of well-controlled conditions in child and adolescent psychoeducational interventions in mood disorders, as well as the effectiveness of these interventions in clinical settings needs to be further established. Psychoeducational group materials addressing the different needs of children and adolescents, different ethnic groups and those who are socio-economically disadvantaged need to be developed (Fristad, Gavazzi, & Mackinaw-Koons, 2003).

Case Management

A wide range of services falls under the umbrella of the mental health system. Services can be placed on a continuum ranging from mild and average difficulties, to severe problems such as dealing with a chronic disorder. The standpoint of case management differs depending on whether the client is a child or adult. Working with youth assumes the inclusion of family members or guardians (Frankel & Gelman, 1998).

There are a variety of models of case management, and the roles and responsibilities of the case manager can differ as well. Woodside and McClam (1998) described three models of case management:

1. *Organization-based case management:* a variety of services are provided for clients through one establishment such as a comprehensive service centre, interdisciplinary team or a psychosocial rehabilitation centre.

2. *Role-based case management:* case management that centres on the roles the case manager will carry out. Examples of this include a *generalist* who coordinates many services, a *therapist* who provides counselling or makes referrals for crisis management, a *broker* who connects a client to other services, or *cost*

containment service that assists people who are unable to make these arrangements on their own.

3. *Responsibility-based case management:* an individual or team such as the family, volunteers, or the client carries out the duties of case management. The agency would make available supervision, training and education.

Comparisons between the models can be made amongst eleven dimensions as set out by Ridgely & Willenbring (1992): 1) *duration:* time-limited, as needed, or indefinite terms; 2) *intensity of contact* can range from low to high; 3) *caseload-staff ratio* can range from low to high; 4) *type of service* can include the case manager providing referrals to providing all services; 5) *focus of service* can range from broad to narrow, inclusive or exclusive; 6) *availability of service* can range from office hours only to 24 hour care; 7) *case management site* can include home, community, office or mixed arrangements; 8) *advocacy* can involve advocating for the client or acting as a gatekeeper to access services; 9) *case manager training* can require on-the-job training, professional or master's degree; 10) *case management team structure* can involve a single caseload (self managed care) to primary or team management and; 11) *case management authority* can be a broad authority which may or may not include a team, a financial authority, or no authority.

The roles and responsibilities of case managers described by Woodside and McClam (1998) are as follows:

- *Direct personal support:* establishing trust, providing empathy and a good working relationship to assist the person in achieving her/his goals.

- *Crisis management*: assessing and making available needed resources in dealing with crisis situations such as suicide, housing, food, or benefit loss.

- *Short-term intervention*: providing one to twelve sessions of counselling. This is conducive to solution-focused approaches that involve specific immediate goals.

- *Broker-facilitator*: providing referrals to other agencies, for example, clients may need access to services that deal with domestic violence or financial assistance.

- *Enabler/teacher/mediator*: assisting clients with independence that can involve a process of "doing for, to doing with, to having clients do for themselves" (p. 37). This can also include mediating between agencies or the agency and the client.

- *Advocate*: can include acting on behalf of clients and their interests; as well, this involves proactive work on behalf of the client population.

- *Service co-ordinator*: comprises an integration of formal or informal short or long-term services.

- *Tracking/follow-up*: evaluating how the client is doing and whether or not the service received was helpful.

Case management in a child and adolescent mental health setting requires specialized knowledge (Walsh, 2000). Awareness of how symptoms of youth and adult mental illness differ is a critical component (Taylor, 1998). Complications that can arise in treatment involve difficulty in clarifying the diagnosis and assessing young children who have difficulty verbalizing psychological problems (Taylor, 1998). There are needs

for more research on medications and psychosocial interventions, as well as community services that are geared less towards younger children and more towards older teenagers and adults (Taylor, 1998).

Case management involves providing service to families, which can centre on the identified client's needs (suicide crisis intervention or counselling), and family factors that influence the child's illness (such as difficulties in obtaining food or shelter). In some situations two case managers of two different programs may need to work together, for example, workers from child protection and psychiatric mental health services (Frankel & Gelman, 1998). Social workers may need to visit the community to educate teachers, activity leaders and families in preventing breakdown of social supports when a child or adolescent is dealing with a severe mental illness (Taylor, 1998).

Research on Case Management Outcomes

Research on case management outcomes has occurred since the 1980's and "in all instances results have been mixed for a variety of outcome indicator such as costs, use of hospitals, client vocational status, and life satisfaction" (Walsh, 2000, p. 33). Research in case management has progressed as different applications in specific populations have been examined (Walsh, 2000).

Case management services for children and adolescents differed compared to adults in a study of 83 youth and 184 adult medical charts of individuals with bi-polar I disorder (Jerrell & Shugart, 2004). Youth received more role-based services that involved assessment and consultation and individual and family therapy, whereas adults were reported to receive more case management services. The case management services were not defined in this study.

A six-year study of the New York Child and Youth Intensive Case Management program (C.Y.I.C.M.) which is a family centred program for youth (ages 18 and under) with mental health concerns found positive results in terms of fewer symptoms of serious emotional disorders, better functioning, and a decreased use of in-patient hospitalizations (Evans, Huz, McNulty & Banks, 1996). Case managers who had a caseload of 10 youth were provided $2000.00 U.S. per child per year to provide individualized services for the youth within a 24-hour intensive case management service. Improvement in problem areas included a significant decrease in "aggressive behaviours, anxiety, suicidal thoughts and behaviours, psychotic behaviour, and fire setting, and cruelty to animals" (Evans et al., 1996, p. 278). The authors recognized that the case management model provided individual service for the child, leaving a need to address the family environment (Evans et al., 1996).

In a study of the utilization of three different case management models with adult individuals who experience severe and persistent mental illness, all three models were found to be effective (Ryan, Sherman & Judd, 1994). Twenty case managers had a caseload of up to 20 clients in a Denver, Colorado public mental health system within a two-and-a-half-year span where 382 clients received service. The three types of case management models studied were: 1) the *community support model* that provided problem solving with significant others, income, family, housing, and other basic resources; 2) the *habilitation-rehabilitation* model that provided vocational, educational, budgeting, and daily living skill support; and 3) the *traditional psychiatric* model that provided medication and monitoring, crisis intervention, identifying illness decompensation, and mental status services. All three models were found to be effective

in improving client adjustment into the community. There was more support for both the community support and the habitation-rehabilitation model over the effects of the psychiatric services model.

Besides showing support for case management interventions, this study was aimed at reviewing whether or not case-managers influenced outcomes. This study controlled for medication effects. Through controlling types of services and client characteristics, the study found case managers to significantly influence client outcomes.

While there is some support for case management interventions as a whole, within the population of child and adolescent mental health more research is needed. In the future, case management research will need to further define case management methods and activities, and examine the impact of the therapeutic alliance in case management interventions (Kutash & Rivera, 1995; Walsh, 2000).

Solution-Focused Therapy

Steve de Shazer and his colleagues Insoo Kim Berg, Eve Lipchik, Elam Nunnally, Wallace Gingerich, Ron Kral, Alex Molnar and Michele Weiner-Davis developed solution-focused therapy (S.F.T.) in the late 1970's at the Brief Family Therapy Center in Milwaukee, Wisconsin (Molnar & de Shazer, 1987).

Ideological influences in solution-focused theory came from many sources. Concepts such as the "miracle question," the use of metaphor, presupposition questions, and focusing on the abilities of the client were influenced by the work of Milton Erickson (O'Hanlon & Weiner-Davis, 1989). O'Hanlon & Weiner-Davis (1989) explained how concepts of treating people as if they were normal instead of by their psychiatric labels

came from Jay Haley and Thomas Szasz, and techniques that used the focus of "clear outcome images" came from the work of Bandler and Grinder.

The idea of brief therapy, that therapy could be done in fewer than ten sessions, was influenced by the Brief Therapy Center at the Mental Research Institute (M.R.I.) in Palo Alto, California (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986). Therapy was conducted with an observing team behind a one-way mirror who provided feedback near the end of the session. The M.R.I. approach used strategic concepts of family interactions to make changes to the problem. The therapy team in Milwaukee adopted the *brief* and *team* treatment approach and applied a new therapeutic stance that centred on building solutions (de Shazer et al., 1986).

The underlying premise in solution-focused therapy is that in order to move towards solutions one must focus in that direction. Revisiting the past for meaning and details can have no bearing on the solution. The solution-focused model and its techniques are based in solutions, helping the client utilize their own resources to move towards their goals.

Principles of Solution-focused Theory

There are 12 assumptions of the solution-focused theory that form the basis of the model and its techniques.

1. "Focussing on the positive, on the solution, and on the future facilitates change in the desired direction. Therefore, focus on solution-oriented talk rather than on problem-oriented talk" (Walter & Peller, 1992, p. 10).

By focusing the conversation on goals, clients begin the process of developing solutions. This is similar to self-hypnotic techniques of sports psychologists who work

on producing a mental representation of the goal. Focusing on solutions allows the therapist to develop rapport. Walter & Peller (1992) referred to an example of a 12 year old who became more willing to discuss positive examples of his behaviour rather than shrinking in the corner after a parent's recitation of a list of problems. The strength of a solution-focused language is that it can generate an emotional reaction even when we only visualise the outcome (Friedman & Fanger, 1991). Solution talk promotes solutions and clients will be reminded of other accounts of positive results or times of resourcefulness in their lives.

2. "Exceptions to every problem can be created by therapist and client, which can be used to build solutions"(Walter & Peller, 1992, p.12).

When problem solving, it is natural for people to become limited by resorting to only one particular view of what the solution to the problem should be. Exceptions of times when the problem did not occur are often dismissed because results were not consistent. In solution-focused therapy, exceptions have importance because they can provide thoughts or behaviours that previously worked for the client. A benefit to the client in reviewing the exceptions of when a problem did not occur is that it can foster a sense of control when the problem seems overwhelming.

3. "Change is occurring all the time" (Walter & Peller, 1992, p.15).

It is not useful to initially get into lengthy discussions of problems and problem maintenance, which precludes discussions on the transition from one state to another. In solution-focused therapy, the focus is on the changes the client would like to see happen, or acknowledging what is working and needs to continue to stay the same. Language is important since using a verb that assumes change can make problems seem manageable;

for example, "someone who is depressed" could be better described as "someone who is showing depression." The assumption of change can make inroads for discussions of exceptions; for example, in times when the person is not depressed. For these concepts to work with adolescents Selekman (1993a) advised: "if you expect change will occur with your adolescent clients, your expectancy for change will influence your client's behaviours" (p. 140).

4. "Small changing leads to larger changing" (Walter & Peller, 1992, p. 18)

Often the case that contains multiple problems or a client with severe dysfunction is judged to require a complex response; however, small changes can create an openness towards seemingly difficult actions not yet taken. Small change is generative. Once a client has achieved some success and can appreciate small changes, s/he has more resources and expectations for handling more difficult problems (Selekman, 1993a; Walter & Peller, 1992).

It is not unusual for parents to mention an exhaustive list of complaints in regard to their adolescent. Selekman (1993a) advised the therapist to keep goals small and realistic and to negotiate with the parents by asking which problem to work on first, as "it is impossible to change breaking curfew, not following parental rules, and truancy all at once" (p. 140).

5. "Clients are always co-operating. They are showing us how they think change takes place. As we understand their thinking and act accordingly, cooperation is inevitable" (Walter & Peller, 1992, p. 21).

The term "client resistance" does not exist in solution-focused therapy. "If we take clients at their word and trust that they want to solve their problem, we can assume

they are trying the best way to solve it in the best way they know at the moment" (Walter & Peller, 1992, p. 20). When people do want to change and are resistant, this resistance is viewed as the client's way of telling the counsellor that more fitting options are needed (de Shazer et al., 1986). Cooperation is inevitable as a result of this therapeutic stance. In family therapy, if any family members do not want to attend, sessions can continue with those who are willing. Those who chose not to attend are not considered resistant, only perceived as working out the problem and possibly thinking about change differently. It is the therapist's role to "listen and observe carefully for clues that help identify our client's unique cooperative response pattern" (Selekman, 1993a, p. 139).

Another way is to build a collaborative approach in working with families who have seen multiple therapists. It is important to inquire into what worked or did not work with former therapists in order to prevent repeating the same mistakes (Selekman, 1993b).

6. "People have all they need to solve their problems" (Walter & Peller, 1992, p.23).

Client resourcefulness refers to their capability to act on a new course of action (Walter & Peller, 1992). People can change to meet their goals. People have the resources to change. A 1990 survey (Gurin, 1990) found 90% of over 1000 Americans conquered a significant emotional or lifestyle problem and less than three percent sought professional intervention (as cited in Durrant & Kowalski, 1993).

When working with difficult adolescents Selekman (1993b) places them in a role of "expert consultant" seeking their advice on the best way to help someone out who is in their position. Difficult refers to severe problems with substance abuse, eating disorders, depression, and delinquent behaviour (Selekman, 1993).

7. "Meaning and experience are interactionally constructed. Meaning is the world or medium in which we live. We inform meaning onto our experience and it is our experience at the same time. Meaning is not imposed from without or determined from outside of ourselves. We inform our world through interaction" (Walter & Peller, 1992, p.24).

Many points of view or explanations can exist of just one event (Selekman, 1993b). This idea is similar to Bateson's concept of "double or multiple comparison" (p. 97).

Meaning is formed by our interactions with events or interactions with people that further transforms meaning. In therapy, when the meaning of a goal, problem, or solution is changed, clients may realize that a problem no longer exists, something different can be done, or they are on the right track (Selekman, 1993b; Walter and Peller, 1992).

To change meaning is to change the experience; for example, to change the meaning of a diagnosis for someone with depression can make a difference in the person's experience, from a person who feels inherently flawed to a person who is unhappy with their circumstances.

8. "Actions and descriptions are circular" (Walter & Peller, 1992, p.26).

"There is a circular relationship between how one describes a problem or goal, what action one then takes, how one describes these actions and results, what further actions one might take, and so on" (Walter & Peller, p.26). Parents can see teenagers as bad or experimenting, and the results can be punishment or other consequences depending on the interpretation implied. Changing the meaning influences future options and following actions.

9. "<u>Meaning is in the response</u>" (Walter & Peller, 1992, p.26).

We can communicate with others and the message received may not be what was intended. If the response received is not sufficient, it is the therapist's responsibility to communicate clearly. The response received indicates whether the meaning of the communication was sufficient or if another alternative is needed. Both the individual and all observers construct meaning.

10. "<u>Therapy is a goal or a solution-focused endeavour, with the client as expert</u>" (Walter & Peller, 1992, p. 28).

Clients, not the therapist, are the decision makers regarding which goals to work on (Lipchik, 2002). A therapist can only make suggestions of goals. When working with an involuntary client, acknowledging negative feelings towards the client's mandated situation can promote a cooperative therapist-client relationship (Lipchik, 2002).

In a solution-focused approach, therapy consists of the co-construction of goals and providing assistance in the solution process. Although the functions of education and support overlap with therapy, Walter and Peller (1992) pointed out distinguishing features that make the other functions inappropriate for therapy. If clients want information on parenting skills they are advised to seek an educational class. A strictly supportive therapy process without goals can be ineffective and may encourage dependence.

11. "<u>Any change in how clients describe a goal (solution) and/or what they do affects future interactions with all others involved</u>" (Walter & Peller, 1992, p.30).

Family problems can be approached with one member present. As one person changes his/her meaning and actions, the interactions between other members change. This is also one of the tenets of systems theory (Nichols & Schwartz, 2001).

12. "<u>The members in a treatment group are those who share a goal and state their desire to do something about making it happen</u>" (Walter & Peller, 1992, p. 31).

Solution-focused therapy is not considered an individual or family therapy. The problem is the "reality" in which people are organized around and "want to reach a shared goal" (Walter & Peller, 1992, p. 32). The therapy unit or group includes the therapist and all those who are interested in reaching a goal. Walter & Peller (1992) described the team approach in solution-focused therapy:

> This is different from those therapy models which assume that the client group is a socially defined unit such as an individual, a family or couple. In other models, the source of problems was assumed to be some dysfunction in one of these defined units...We avoid reifying diagnostic maps of units like individual, family or psyche. This is not an individual therapy and not a family therapy. This is not a model built upon organizational constructs...Their organization, if you will, comes from their joint purpose of wanting to solve the problem or reach some shared goal (p. 32).

In helping the youth reach its goal(s), workers from other agencies may be involved. "Multiple-helper meetings" with other workers from child protection, the justice system, school, or psychiatric hospital that may not be available for sessions, yet may be involved with the adolescent are recommended (Selekman, 1993a). These meetings may occur in the worker's office and can be advantageous when a team effort is focused to look for certain changes.

Intervention Techniques

Questions can be more important than the response since they encourage the client to think differently about their situation. These are called pre-suppositional questions that are "tools for eliciting the client's outcome goal, conveying the inevitability of change, and for co-creating a future reality without problems" (Selekman, 1993a, p.142). The questions themselves become the interventions (O'Hanlon & Weiner-Davis, 1989). Berg and Miller (1992) explained five types of questions used throughout the counselling process:

Pre-Session Change Questions

Often clients will think about their problem and work on the solution from the time they made the first appointment until the first session. Questions focused on the pre-session tap into changes that were made before the first interview.

Miracle Question

The miracle question was derived from Erickson's "pseudo-orientation in time" technique that has a client place him or herself into the future with the problem solved (O'Hanlon & Weiner-Davis, 1989; Selekman, 1993a). The miracle question is used to formulate goals and tasks: "Suppose that one night, while you are asleep, there was a miracle and this problem was solved. How would you know? What would be different?" (de Shazer, 1988, p.5)

Exception Questions

Exception questions look at previous (or present times) when the problem did not occur. Clients become aware of times when they had control over the problem. Exceptions are used to derive behaviours from the situation that work for the client.

Scaling Questions

Scaling questions are used to elicit information and to confirm meaning. A goal is set on a scale from one to ten and the client determines what needs to change in order to move on the scale. The increments are not based on exact measurements of a standard that is external to the client. The function of the scaling questions are to: "measure the client's own perception, to motivate and encourage, and to elucidate the goals and anything else that is important to the individual client" (Berg & de Shazer, 1993, p.10).

Coping Questions

Coping questions are used when the client experiences immense hopelessness and the task of identifying solutions becomes difficult. Questions center on small steps; for example, a client is asked how he or she manages to cope with daily tasks such as getting out of bed.

Past, Present and Future Time Frames

A focus on the future is essential in a solution-focused approach. As clients imagine themselves in the solution and create maps, change is set in motion (Mittelmeier & Friedman, 1993). Since change is assumed to be constant and always occurring, the present is explored for exceptions, or to identify the starting steps in the solution process.

A solution-focused approach is different from other therapy models in handling the past. Past experiences are not denied, nor are they to be explored in a manner that reinforces the problem talk associated with it. The therapist role is to handle the past in a carefully skilled and focused manner, looking for past strengths and solutions that can be the basis of a new solution. "*Amplification* rather than *excavation*" is the rule to prevent getting lost in past details (Mittelmeier & Friedman, 1993, p.180). The therapist must use

her/his judgement when exploring the past. Selekman (1993a) advised avoiding a rigid application of the model as some families may have experienced a traumatic event and need the support and validation of the therapist.

The Therapy Process

In other models of brief therapy, such as the Milan Model, each session is 3 hours with the therapist being in charge of therapy and the team behind the mirror acting as a consultant. In solution-focused brief therapy the team is in charge and the hour session is divided as follows:

1. 40 minute interview

2. 10 minute consultation break

3. 10 minute break for intervention message, compliments, and ending session.

The same structure is used if an individual counsellor is working alone (Molnar & de Shazer, 1987).

In the process of therapy, all tasks are applied as necessary in the first session. The second and remaining sessions continue with the co-construction of solutions until the goal is met. In the beginning of the intervention the therapist will move from a *complaint statement* - a description of the problem that prompted the family into therapy, to a *solution statement* - a description of what the client will be doing once the problem is solved (Molnar & de Shazer, 1987). Complaint statements can range from vague to detailed; more details provide a future comparison to know the problem is resolved (de Shazer et al., 1986). Once complaints are explored in the first session there is no need to return to the complaint in subsequent sessions (de Shazer et al., 1986).

Moving too fast into the solution statement can be ineffective since this can leave a client feeling misunderstood and not listened to (Selekman, 1993b). At other times there may be a lot of problem talk and moving into the miracle question right away can help to move towards clearer outcomes (Selekman, 1993b). In cases of grief, sexual abuse and trauma, Durrant & Kowalski (1995) suggested letting the client determine how much disclosure is needed in order to be helpful. In situations of previous trauma, the therapist will need to follow the client's lead, looking for indicators that the client will be willing to move into solutions (Durrant & Kowalski, 1995, Selekman, 1993). The therapist will need to make a judgement call to determine when to move into solution development.

Tasks

In order to help clients see exceptions to problems, de Shazer and Molnar (1987) stated that several interventions are suited to the level of readiness of the client to focus on solutions.

Some clients may not be able to move beyond a strong problem focus. In this case, stability is needed and the *formula first session task* is given which asks clients to identify what they want to see continue. de Shazer and his colleagues developed the formula first session task for the end of the first interview: "between now and the next time we meet, I would like you to observe, so that you can describe to me the next time, what happens in your family that you want to continue to have happen (Molnar & de Shazer, 1987, p. 349). If the client is able to identify some degree of success, tasks then centre around amplifying and exploring solutions. The client can be asked to: 1) continue

to do more of the satisfactory behaviours, or 2) notice what they are doing at the times when they overcome temptation.

When a client struggles with identifying exceptions they need to build their awareness of exception rules and learn about the context in which solutions are built. These types of tasks are referred to as *observation tasks*. To help with this, the end of session tasks can be used to ask the client to: a) do something different and report back as to what happened; b) keep a log of when the problem does not exist; c) at the beginning of the day pre-determine the rate that exceptions occur and at the end of the day compare this to the actual occurrence; and, c) look at why a very difficult situation is not worse.

For parents who are quite "over involved and highly reactive" Selekman (1993a, p. 143) assigns an observation task to increase awareness of improvement in their adolescent's actions. This can help parents to distance themselves from the problem in order to make room for the teenager change his or her behaviour in an encouraging way.

Solution-focused Family Therapy with Adolescents

Therapists will work with part of the family if some members do not want to participate. In adolescent families, much can be accomplished with the parents if the adolescent has chosen not to attend sessions (Selekman, 1998a). Families are assumed to have an ability to change. If the adolescent shows up for the first session, s/he is also assumed to be capable and resourceful. Some adolescents are involuntary clients and will act like a "window shopper." Selekman (1993a) advised three options for engagement:

1. Acknowledge and respect the goal the adolescent chooses.

2. Align with the adolescent and assist in getting the referring person off his/her back.

3. Take a one down position and ask the adolescent to help the "confused and incompetent therapist" on how the teen was forced into counselling (p.154).

Three options were recommended by Selekman (1993a) when a therapist is stuck in an adolescent case:

1. Reassess goals: change the goal or make a large goal more manageable.

2. Have a colleague observe a session and give feedback.

3. Place the family in an expert position and ask how best to treat a family in their situation.

Whether working with an individual, family, or group a sense of humour or playfulness can help in a clinical setting (Mittelmeier & Friedman, 1993; Selekman,1993b). The use of role-plays in the setting can help families move into the solution situation and further promote understanding (Mittelmeier & Friedman, 1993).

In a group or family setting tasks involve each member. Asking each member one small thing they can do to move towards the goal or one small action each person can take give to help move the process forward (Mettelmeier & Friedman, 1993).

Family Therapy with Adolescents in a Mental Health Setting

The solution-focused model has applicability in an adolescent mental health setting. Problems that are handled in this setting can include eating disorders, depression, suicide, aggression, defiant behaviour, psychosis, school-related problems and running away. Miccuci's (1998) discussion of family therapy with adolescents indicates similarity to a solution-focused approach in the following ways:

1. The therapeutic focus is on helping the family support their adolescent in functioning instead of removing psychotic symptoms.

2. Family competence is supported when parents present as being overwhelmed with the problem youth.

3. When families are stuck in a symptomatic cycle they may only use limited ways of coping. The therapist's job is to help the family expand their view on their range of abilities.

4. The therapist is to help the family focus away from the symptomatic cycle and point out the exceptions the family may not notice.

5. Small steps of improvement are encouraged.

6. Family strengths are emphasized.

The solution-focused approach has limitations with the adolescent population. A problem focus is required for understanding family situations. Families need to vent when facing the after-effects of chronic problems (Milkowitz & Hooley, 1998). Education and understanding are needed in regards to the diagnosis and its symptoms. Families may have experienced past trauma and may need to discuss this at length. Limits of the client's abilities in regard to his or her illness need to be respected.

Alternative Approaches of Solution-Focused Therapy

One major challenge in using the solution-focused approach involves helping clients to move from a problem focus into solution building. As the solution-focused approach evolves more literature attempts to address this issue in several ways (Efron & Veenendaal, 1993; Klar & Berg, 1999; Lipchik, 2002; Selekman, 1993a; 1993b) As these new variations in the solution-focused approach surface, debates arise as to whether or not the techniques are theoretically consistent or true to the solution-focused approach (Miller & de Shazer, 2000). The purpose of this section is to review the different ways in

which this challenge is addressed by: 1) using a completely different intervention outside of solution focused therapy; 2) combining different interventions with solution focused therapy; or 3) finding new approaches within solution-focused theory.

Moving away from the solution-focused approach and incorporating techniques of other models is one way of helping clients move into solutions. The narrative approach that shares the constructivist basis with the solution-focused approach provides one example. The concept of externalizing the problem, developed by Michael White, is often integrated with the solution-focused approach (Selekman, 1993a). Selekman (1993) found it useful to combine the narrative therapy technique of *externalizing the problem* with "highly entrenched adolescent cases" where families were not responding well to co-creating solutions and needed to have their problems understood and validated. In this situation the problem was described as an external entity, "when depression gets the best of you, what kinds of things do your parents do to help you stand up to it?" (Selekman, 1993a, p.145). Providing a wide-ranging list of these approaches is outside of the scope of this project, but incorporating approaches into a solution-focused framework is important in providing different tools to assist clients. Although Selekman's work is a good example of how other models are integrated, it is important to note that he also developed and contextualized the solution-focused approach with children and adolescents (1993a; 1993b).

A second approach involves a combination of solution-focused therapy with another model. These techniques are not a pure solution-focused approach, yet the meshing of the two contains elements of both models. Efron and Veenendaal (1993) recognize that non-miracle questions produce realistic alternatives and allow room for the

client to accept and discuss painful realities without the pressure of having to "rise above the pain, find something positive in it, or go on living as if it had not occurred" (p. 17). Their viewpoint combines concepts of strategic therapy with solution-focused techniques by promoting change through acceptance.

Examples of combining strategic and solution-focused questions that fit with the mental health population are: 1) If we can't really change the problem, how can we dull the pain of having to live with it?; 2) Would it help even a bit for us to be able to help you lower the pain from 9 out of 10 to 8 knowing that you will never get to any lower number?; 3) We don't know how to help you now with your problem. Maybe in the future somebody will find out how to help. What would help you wait till then?; 4) If you can not overcome your fate or your past, and you have to live a marginal life, what would make it more tolerable?; 5) If we can't erase your experiences, and that looks like it will be the case, what goals might you still set for yourself?; and, 6) If you can not overcome your fate or your past, what could you do for your children or loved ones (or community, etc.) that would make you feel that your life had at least a little meaning? (Efron & Veenendaal, 1993, p. 16).

The third and final way to help clients move into solutions involves working within the model itself and enhancing the techniques (Klar & Berg, 1999). The solution-focused approach has been enhanced by: 1) finding new approaches in a family setting; 2) examining the role of emotions; 3) dealing with past issues; and 4) goal setting.

One of the basic principles of solution-focused approach is that people are not organized around family structures such as subsystems and instead are organized around a problem (Walter & Peller, 1992). The same techniques are applied in a family setting.

The question of how family therapy differs from individual or group therapy is not fully addressed. This is not to say that therapists have not completely ignored nor written about family therapy using a solution-focused approach in interactional terms; however, there is a need for more enhanced literature on this issue on how to stay within the model.

The challenge of applying the techniques in a family atmosphere has been addressed by Klar and Berg (1999). Compared to an individual modality, in family therapy, members have a high emotional investment with each other that results in the need for new approaches in applying S.F.T. techniques in a family setting. Setting shared goals can be challenging amongst family members and the authors recommend setting goals in interactional terms: family members who are often let down by other members' habits need to be included in the process. This includes paying attention to pace and timing by not pursuing solutions too far in advance of other complaining family members. Family members are to be included in a resourceful manner by seeing what each member can contribute and by confirming changes that are made (Klar & Berg, 1999).

Focusing on the role of emotions in the solution-focused approach has helped clients make the shift from problems into solutions (Kiser, Piercy, & Lipchik, 1993; Lipchik, 2002). Lipchik (2002) describes the power and importance of having clients verbalize and describe emotions: a) addressing emotions can lead to more detail when complaint statements are vague; b) more solution options can be found where the emotions have been addressed; and c) it contributes to an emotional climate that is conducive for solution building and setting goals. Solution-focused therapy does not view emotions as "separate, mysterious, private, and non-social aspects of therapy

relationships" (Miller & de shazer, 2000, p.9). Emotions within their social context are viewed as a resource to the solution building process (Kiser, Piercy, & Lipchik, 1993; Lipchik, 2002, Miller & de Shazer, 2000).

Helping clients to deal with the past can be challenging. The therapist can amplify past solutions (Mittelmeier & Friedman, 1993), or respect the client's pace and timing when addressing trauma (Durrant & Kowalski, 1995; Selekman, 1993b). In situations where couples cannot move beyond past hurts, or adult children talk about the past wrongs of their childhood, asking clients what they need to help in order to move forward is one way to address the past (Lipchik, 2002).

Goal setting is another area that can be misleading. Clients may select poor fitting goals if there is too much pressure put on them by the counsellor, especially in the first session. Lipchik (2002) uses the metaphor of shopping; clients need time to shop around, may decide on something else after looking around, and occasionally, but rarely may find what they want on the first try. Lipchik (2002) recommends: 1) taking the goal setting process slowly and letting clients consult with counsellors to determine what they want from therapy; 2) "clarifying goals" over "redefining goals" to avoid unnecessarily shaming clients for not meeting ill defined goals (p. 82); and 3) recognizing that the goal setting process occurs up until the last session.

Helping clients move into solution can be challenging while trying to remain consistent to the theoretical basis. Eve Lipchik (2002) has summed up an important therapeutic perspective that "we should think of ourselves as first as human beings, second as therapists, and only last as therapists who practice a particular model" (p. xvi).

Solution-Focused Outcome Research

Solution-focused therapy has grown into a mainstream model of therapy in the past twenty years and as a result there is a need for more empirical support. Gingerich & Eisengart (2000) conducted a review of the studies up until and including 1999 and found a shift from the "open trial phase to an efficacy phase" (p.495); most studies using solution-focused approaches relied on client satisfaction surveys, whereas few studies had emerged with well-controlled designs.

The use of solution-focused brief therapy was studied in a family setting where one adult member dealt with chronic schizophrenia (Eakes, Walsh, Markowski, Cain, & Swanson, 1997). The family member who had schizophrenia received medication and solution-focused brief family therapy after a ten week period. This was compared to a control group that received traditional therapy and psychotropic medication. This study used the Family Environment Scale (FES) at pre-test and post-test, which were compared to a control group who received traditional therapy and medication over the same period. Clients were surveyed to learn about useful aspects of therapy. "Being supported or validated" was cited as most helpful whereas rigid use of techniques was least helpful. None of the respondents who felt the therapist was rigid (too insensitive, inflexible or too positive or artificial) had met their goals.

Although the sample size was small (n=10) the preliminary findings (Eakes et al., 1997) are noteworthy. This study found statistical differences on the Family Environment Scale (FES) in the areas of expressiveness, active-recreational orientation, moral religious emphasis, and incongruence in the experimental group compared to the control group. The authors explained this as improvement in areas of expression,

recreational activities, and belief in the ability to handle problems (using one's own resourcefulness instead of relinquishing control to a religious belief). The area of incongruence improved, as families were able to attain shared knowledge about their circumstances and each other as they related to the illness.

Areas that did not change significantly on the FES were cohesion, achievement orientation, conflict, independence, achievement orientation, intellectual-cultural orientation, organization, and control scales. Although areas of improvement in the other dimensions occurred over the course of five sessions, the authors suggest that areas that were not affected may have been due to a small impact of the Brief Solution Focused Therapy model, or that more treatments were needed.

A follow-up of using solution-focused brief therapy conducted with families was done at the C.M. Howes Centre in Toronto. A success rate of 64.9% (n=59) was found in goal attainment using brief solution-focused therapy at a six-month follow-up period (Lee, 1997). Of the 64%, 54% had met their goals, 10.6% partially met goals, and 83.6% found therapy as an overall helpful experience. An average of five and one-half sessions were held using a team approach that may have included students who were supervised.

In reviewing the relationship between reported problems and selected goals Lee (1997) found support for the theory that solutions are not directly related to problems. School-related problems were reported as the main complaint (42.4%) but were the third last goal chosen (11.9%). The author noticed parents tended to choose goals that they had more control over and focused on themselves.

Goal attainment was not related to a systems belief that all family members must attend for maximum benefit. Not all family members attended sessions. Solution-focused

therapy worked well for the diverse backgrounds of this sample as people were of different ages (adults and children ages four to seventeen), sexes, family structures, parental occupations and parental educational levels.

Another follow-up study of solution-focused brief therapy (S.F.B.T.) was applied in a rural community adult mental health setting (Macdonald, 1997). The S.F.B.T. approach involved the use of client directed goals, exceptions, scaling, the miracle question, and a written letter of the closing intervention of each session was mailed out to the client as reinforcement. Sessions ranged from 1-12 and follow-up was completed one year after the last session. Follow-up reports were made up of 36 cases (14 individuals, 18 couples and 4 families with clients ranging in age from 18-63 years) completed by either the attending or general practitioners. Sixty-four percent (64%) of the respondents reported a good outcome in problems dealing with anxiety, depression, relationships, and overuse of alcohol or tablets. In terms of goal achievement of 18 respondents, 9 in the good outcome group achieved their goal, 5 had achieved only part of their goal, compared to the other group where 2 had achieved their goal, and 2 had not. There were no statistically significant differences between these two groups. This study cannot be generalized to another population.

Although Gingerich & Eisenhart (2000) acknowledge there is some support suggesting effectiveness in certain situations, obstacles to demonstrating the efficacy of the solution-focused approach include: 1) the need for a clear, consistent, well-defined approach; 2) the need to overcome methodological problems such as large sample sizes and comparisons to a non-treatment group or a proven efficacious treatment group; and 3) the publishing of reports that show negative results. Even when an approach has

proven to work in a well-controlled research environment, generalizations cannot be transferred into a practice setting (Hoagwood, Burns, Kiser, Ringeisen, Schoenwald, 2001).

Conclusion

Adolescents have different needs than adults in dealing with a mental illness. In either case, the family plays an important role in the support of a member's recovery from mental illness. A variety of therapeutic adjuncts are beneficial to families in meeting their unique needs. Family psychoeducation in adolescent mental health is emerging and is supported by the benefits to consumers in the adult population. Solution-focused intervention aims at building a collaborative atmosphere in which to support the adolescent. Psychoeducation, solution-focused and case management interventions are complementary in providing knowledge and support aimed at enhancing the family environment of the adolescent.

CHAPTER THREE - METHODOLOGY

Introduction

An overview of the methodology of this practicum project is presented in this chapter. This practicum took place at the Intensive Child & Adolescent Treatment Services (I.C.A.T.S.) at the Health Sciences Centre in Winnipeg, Manitoba. The project setting, client population and selection, committee functions and project evaluation are described.

Setting

The Intensive Child & Adolescent Treatment Services program started to provide services in July 2001 and had been running for over two years when this practicum commenced. It is a hospital outpatient unit that co-exists with over 22 mental health service programs in the Psychealth Centre building. The I.C.A.T.S. program provides short-term services to youth and their families who are in acute crisis. This program is distinct from the long-term Outpatient Mental Health Service (O.H.M.S.) program that is offered in the same hospital.

In this placement the student was required to become acquainted with the hospital setting by attending orientations and to gain familiarity with other social workers in neighbouring settings. One orientation was given by Health Sciences Centre to get the student accustomed with policy and procedures of the large hospital organization. A second orientation was held by the PsycHealth Centre to aid new employees and the student in becoming familiar with all mental health programs. There was an opportunity to meet with other social workers in the hospital. This included regular meetings social workers from other mental health programs and the social work council that provided a

forum to address concerns of social workers in the entire hospital. This placement also included a unique opportunity to participate in a meeting that included social workers from the St Boniface hospital who worked in programs for youth.

Clients

The I.C.A.T.S. program serves the youth population who are primarily dealing with mood disorders such as depression, bi-polar disorders (manic depression), as well as youth with post traumatic stress disorder, psychotic features or substance abuse disorders. Youth with primarily anxiety disorders are frequently referred to programs at the St. Boniface hospital; however, it is not unusual for youth who exhibit secondary traits of anxiety to receive services in I.C.A.T.S. The I.C.A.T.S. program services are geared towards youth who benefit from short-term services. Youth who benefit from long-term programs are referred to the long-term outpatient program or community programs such as the Manitoba Adolescent Treatment Centre.

In the ICATS unit, only psychiatrists make referrals to the program from three different sources:

1. Children's Emergency department
2. The hospital in-patient unit
3. Crisis Consultation Unit

The program serves as a "step-up" or "step-down" unit by providing support to clients to prevent a hospital admission; or, to provide supports to clients who reintegrate into the community after a hospital admission. Individual, family, group and medication management interventions are offered by a multidisciplinary team of professionals that includes psychiatry, nursing, social work, occupational therapy and physical recreation. Case-management responsibilities are delegated to social work, nursing, or occupational therapists within the team.

This practicum report discusses three types of services with adolescent families provided by the student: case-management, solution-focused family therapy and group psychoeducation for parents. The practicum took place over a seven-month period; the psychoeducational group consisted of seven sessions. The group overlapped with family interventions that were seen over a three-month timeframe. In solution-focused family therapy, six families were seen and forty-three sessions were held. Families attended an average of four to nine sessions. These families were referred from the in-patient unit and one family was referred from the children's emergency department for family treatment.

Recruiting clients for the parenting group in contrast to family therapy was not an easy process. The barriers to the group will be discussed at length in the chapter on group intervention. In the final stage, the recruitment pool was extended to parents who have youth receiving long-term services from the Outpatient Mental Health Services program.

Committee Members and Supervision

The committee was comprised of three members to oversee and supervise this project. Dr. Brenda Bacon is the academic advisor from the Faculty of Social Work at the University of Manitoba. Meetings were held with Dr. Bacon on a monthly basis to provide supervision of solution-focused therapy and direction for the overall project. Brad Brown, M.S.W., family therapist with the I.C.A.T.S. program since its services commenced, provided on-site supervision. Dr. Tuula Heinonen, also from the Faculty of Social Work at the University of Manitoba, was helpful in the beginning and final stages for ensuring social work standards in this practicum.

There was both on-site and off-site clinical supervision for this practicum. Supervision of the student occurred in the areas of case management, family and group

interventions, and all areas related to the agency including team dynamics, hospital policy, and agency recording procedures. On-site supervision included regular weekly meetings with Brad Brown, M.S.W. In these meetings we reviewed progress in the group and family interventions, which included reviewing videotapes of family sessions. Almost daily supervision occurred as each session was debriefed and chart summaries were reviewed. After each family session, the student wrote a self-reflection report summarizing the strengths and weaknesses of her work in the therapist role. Off-site supervision meetings were held with Dr. Brenda Bacon on a monthly basis to review the use of solution-focused interventions with families, as well as to review segments of the videotaped sessions.

Written permission from clients was obtained for participating in the practicum (see Appendix A). Clients were informed of the purpose of the learning project prior to receiving family or group interventions. Participants were informed that consent was voluntary and anonymity was maintained. Four of the six families provided permission for videotaping sessions (see Appendix B). Video sessions were erased after being reviewed by the student with either the faculty advisor or on-site supervisor.

<div align="center">Evaluation</div>

Group and family evaluation occurred in similar and yet different ways. For group evaluation, a modified version of the Client Satisfaction Questionnaire-8 (C.S.Q.-8) was used. Family evaluation used the C.S.Q.-8 along with solution-focused scales and the FAM III measure. A description of each measure follows.

The FAM III

The FAM III was developed by Skinner, Steinhauer & Santa-Barbara (1983) in order to provide on overall view of the family functioning system. The purpose of this measure is to provide additional assessment information and is not to replace clinical observations. The measure consists of three different components: the general scale, dyadic relationship scale, and the self-rating scale. In this practicum the general scale was administered to families and took an average of 20 minutes to complete. The scale can be administered to youth as young as 10-12 years of age. The FAM III was based on the norms of 182 clinical and non-clinical Canadian families that consisted of 433 individuals (Skinner, 1987).

The FAM III (Skinner et al., 1983) looks at family functioning in seven areas:

1. *Task accomplishment* refers to the family's ability to accomplish what is necessary in the areas of problem solving, crisis, and life cycle changes.

2. *Role performance* refers to the ability of the family to integrate roles, and to adapt to new functions when needed.

3. *Communication* addresses whether communication is clear, direct and the intended message is the one that is received.

4. *Affective Expression* examines whether affect is of a full range, appropriate in timing and intensity.

5. *Affective Involvement* looks at the degree of members' concern with one another, whether it is empathic and supportive, or excessive and intrusive.

6. *Control* refers to how members influence each other; for example, this can refer to power struggles, shaming, and blame, or for constructive purposes such as redirection and education.

7. *Values & Norms* examines how members function within the rules. This also takes into consideration the influence of culture and whether tension exists between family values and society.

8. *Social desirability* looks at how members compare themselves to other families.

9. *Defensiveness* examines whether the respondent is in denial about his or her family situation.

Scores were determined by adding up point values of each subscale and converting these to a chart of standard scores for either youth or adults. The standard scores were then plotted into a chart area. For the first seven dimensions, a rating score between 40 and 60 indicated that the score is in the range of the majority compared to sample norms. A score under 40 indicates a source of family strength while a score over 60 refers to a disturbance. If family scores tend to cluster around one score level this can confirm the validity of the score. Scores represent the individual member's perspective. A problematic score for an individual does not mean the individual has a behavioural problem in that area, it refers to the individual's perception of a problem. If an individual indicates a disturbance in a certain area this could be interpreted as reacting to another family member's functioning. High or low scores out of range for the last two dimensions that represent responder's bias, social desirability and defensiveness, indicate a distortion the measure is not sensitive to.

The FAM III has a demonstrated internal consistency and reliability. Reliability ratings refer to the consistency of a measure, measuring the same thing in the same circumstance. Internal consistency refers to the degree in which the different parts of the scale measure the same thing. Co-efficient alphas are .93 for adults and .94 for children. Differences can exist between clinical and non-clinical families where mothers have more pronounced scores: mothers from clinical families rated their families as more disturbed compared to mothers from non-clinical families who tended to give their family higher ratings (Skinner, 1987).

The Solution-Focused Scale

The solution-focused scale was used as an additional measure in family evaluation. The solution-focused scale is derived from the solution-focused model and has a variety of uses. Using a scale from 1 - 10 clients identify the anchors of the best outcomes for their goal(s). Scaling questions are used as a therapeutic intervention and as an evaluation tool. Self-anchored scales were chosen as a family measurement device due to their fit with the solution-focused approach. As well, self-anchored scales are flexible and sensitive to clients' goals and progress.

Although solution-focused scales are derived from the solution-focused model, and they share similarities with the individual rating scale, the target complaint scale and the individual problem rating scale. Bloom, Fischer & Orme (1995) discussed the effectiveness of individual scales. Individual rated scales have high face validity but may not always provide accuracy of situations, thoughts or feelings. These scales have a high reactivity that is conducive to solution-focused therapy where the client is to maintain

focus on positive outcomes. Data from the scaling questions were collected at pre and post-test points, follow-up, and on client progress when suitable with client goals. Advantages of self-report measures include portraying change over time, including intensity of targets, and capturing internal thoughts and feelings that may not be noticed by standardized measures.

Franklin, Corcoran, Nowiki, and Streeter (1997) described the use of self-anchored scales with single-subject designs and other measures. Baseline measures can be obtained from retrospective data given from clients in the first interview, case records, and intake notes. Measures can supplement outcome evaluation with scale readings that are taken at pre and post intervention.

Franklin et al. (1997) described the advantages of self-anchored scales: a) the client defines the anchors, using their own language and meanings; b) scales are relevant to client experience, whereas other measures may be insignificant to client goals; c) there is less likelihood that evaluation may take over the therapeutic process; and, d) self-anchored scales can show change whereas some measures may not be as sensitive for use with brief therapy. Disadvantages are that scales are limited in use for statistical analysis as baselines often do not vary in solution-focused therapy and obtaining a high level of reliability in self reported data can be difficult (Franklin et al., 1997).

The Client Satisfaction Questionnaire-8 (C.S.Q.-8)

The third measure used for evaluation was the client satisfaction questionnaire-8 (C.S.Q.-8) in both the family and group settings (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). The scale was developed by Attkisson (1985) and contains eight questions to evaluate client satisfaction with treatment (Corcoran & Fischer, 2000)(see

Appendix C). For group evaluation, a modified version of the Client Satisfaction Questionnaire-8 was used (Appendix D). The scale was adjusted to measure satisfaction with certain group activities and the same anchors were used on the questionnaire.

Reliability and validity refer to the error of measurement in a scale (Bloom, Fischer, & Orme, 1995). Reliability ratings refer to the consistency of a measure, measuring the same thing in the same circumstance. Internal consistency refers to the degree in which the different parts of the scale measure the same thing. In terms of reliability, the C.S.Q.-8 (unmodified version) has an excellent rating of internal consistency with co-efficient alphas of 0.86-0.94 (Corcoran & Fischer, 2000). Validity refers to measuring the concept intending to be measured. In terms of concurrent validity, referring to confirming the measure with another valid measure, the C.S.Q.-8 it is rated as very good (Corcoran & Fischer, 2000).

Student Evaluation

An on-going review of student progress occurred at meetings with Brad Brown and Dr. Brenda Bacon. The videotaping of sessions as well as a written review of each session was used to obtain feedback. A journal was kept to note observations, reflections, and skill development in clinical practice.

Conclusion

An overview of the methodology of the different practicum components has been described. Social work ethics were maintained in practice. This included informing clients that they were participating in a student practicum and obtaining written consent from them. Committee participation, supervision and evaluation were essential in guiding the student towards her objectives in this practicum.

**CHAPTER FOUR – FAMILY AND
CASE MANAGEMENT INTERVENTIONS**

Introduction

The model of case management followed in this practicum can be portrayed by

characteristics of the *organizationally-based* and *role-based* models of case management

(Woodside & McClam, 1998). In this hospital organization, the case management

authority was the interdisciplinary team. In each case, the case manager was determined

by the primary roles needed in each situation. If family therapy was required, the social

worker would be assigned; if occupational therapy was needed the occupational therapist

would take the role; a nurse would be case manager if individual therapy was needed. In

situations where more than one type of service that included family therapy was needed,

the social worker would take on this responsibility.

Using the criteria by Ridely & Williamberg (1992) described in chapter two, the

I.C.A.T.S case management model is characterized by many features. The *duration* of

the contract is short-term and time limited where service was provided for up to three

months. Contract *intensity* can range from low to high, where some families are

contacted sporadically and others may seek contact on a more frequent basis. The case-

management *site* is usually in the outpatient offices, yet *advocacy* may require outside

visits (i.e. school, etc.). Case management *training* involves a professional degree since

the role of a social worker is to also provide a treatment service, e.g. family therapy.

The role of the case manager (Frankel & Gelman, 1998; Woodside & McClam,

1998) in this site was to serve as the co-ordinator of services since the client may be

involved with different intervention modalities (individual, group, family, or medication

management). One major role of the case manager was to provide *short-term*

intervention that consisted of up to 12 weeks of intervention. *Crisis management* involved helping clients to connect to appropriate resources such as Children's Emergency or the youth mobile unit in the community. In circumstances where another case manager was involved from other agencies (probation or child protection), the case manager would take on the role of *mediator*.

Once the referral was received, the multi-disciplinary team (made up of a Nurse, Occupational Therapist, Psychiatrist, Recreational Therapist, and Social Worker) decided which services are indicated, who will be the case manager, and who will need to be present at the intake meeting. An intake meeting was held with the family and staff to determine if the services were suitable for their needs and their schedule. The case manager was assigned to the family as the main contact person to handle concerns for the service contract.

A written summary of assessment information gathered by other professionals prior to the initial I.C.A.T.S. assessment could have contributed to the student being able to recruit families quickly for the practicum. It was anticipated through the student's established practicum objectives that the student would attend many assessment or one-time only sessions since families might not have followed through with family therapy; however, this was not the case. A written pre-screening assessment referral was provided by the referring psychiatrist, which was further screened by the I.C.A.T.S. multidisciplinary team prior to meeting with families. To become acquainted with social work practice in the program the student attended a few assessments and observed the supervisor in sessions.

One major component of this practicum involved learning and applying family interventions within a case management model. During the practicum in the I.C.A.T.S. program, the writer had the opportunity to work with six different families. The following sections present and describe how solution focused therapy and the case management model were utilized with these six families during the course of treatment. The names have been changed to protect client confidentiality.

Family One

Presenting Problems

The first family the writer saw was the Maxell family. It included parents Mark and Marie and their two daughters, Jennifer, thirteen years old and Leah, five years old. Mark worked in the plant for a local industrial company and Marie worked part-time in a local grocery store. The family was referred to the program after Jennifer was treated at the in-patient unit. Jennifer was experiencing the onset of hallucinations and had a current diagnosis of Major Depressive Episode (M.D.E.) with psychotic features.

The family attended a total of 4 sessions. Between the third and fourth sessions Jennifer was admitted back into the in-patient unit as she felt she had little control over suicidal thoughts. Mark and Marie attended the last session together. Leah, the youngest daughter did not attend family sessions. Themes in treatment that were raised were building trust with an adolescent, communication, and medical concerns of diagnosis and medication.

Solution Focused Therapy.

One of the first underlying principles of solution-focused therapy is to focus "on the positive, on the solution, and on the future [which] facilitates change in the desired direction. Therefore, focus on solution-oriented talk rather than on problem-oriented talk" (Walter & Peller, 1992, p. 10). In the first session the writer was careful to make sure she heard every from every family member (Nichols & Schwartz, 2001). One of the writer's initial questions was "What needs to change as a result of coming to therapy?" This question was *pre-suppositional* in that it assumes the family has an ability to change and the knowledge to identify what needs to change (Selekman, 1993a). Each family member had different goals in mind. Marie wanted the family spend more time together. Mark did not like feeling that he was an outsider and also he did not like how his daughter spoke to him. Jennifer wanted to be trusted more by her parents. One advantage of using this question in the initial session was that family members usually demonstrate that they know what needs to change (Klar & Berg, 1999). One limit of goal setting at the onset of counselling was that final goals can be "far removed from what clients thought their goal was when they entered therapy" therefore, goal setting can occur throughout the course of treatment until termination (Lipchik, 2002, p. 79).

Solution-focused therapy techniques or tasks are to be utilized as necessary within the first session and throughout the counselling process (Molnar & de Shazer, 1987). The scaling question was used at the outset since it was useful for acquiring a baseline and drawing out information that the client views important (Berg & de Shazer, 1993). In the first session there was only time to partially apply this technique to Jennifer's goal of wanting her parents to trust her more. A few months prior to the first session, Jennifer

disclosed to them that she had experimented with drugs. Initially Jennifer identified that she felt at a level one of trust when her parents searched her room and email account. She stated that she was at a level three of trust when they constantly lectured her on drug use. Jennifer interpreted this as a reminder that she was a bad person. In the following session she remarked that trust had changed to a level seven. When the writer inquired into what made the rating higher (Berg & Miller, 1992; Klar & Berg, 1999), Jennifer explained positive steps her parents had made such as being more flexible and allowing her to go out the same day she asked to go out. Her parents commented on their struggle between trusting Jennifer and not closing an eye to drug use. They thought Jennifer might have been into drugs again when they noticed a odd smell in the kitchen. They did not discuss this with her. Later they found out it was from the new stove.

This attempt at scaling was limited as an intervention in two ways. First, the scaling question should not to be used in relation to problems, but to comment on solution statements (Klar & Berg, 1999; Berg & de Shazer, 1993). The counsellor inquired what made the score of three higher than one, instead of looking into why the rating was low. Second, using the question too soon resulted in the client focusing on negative aspects of the situation. This was a good indication that more time would be needed to hear out complaints from Jennifer and her parents. Techniques work best when clients are ready to move into solutions (Lipchik, 2002).

Scaling was useful since it both provided a baseline and elaborated and conveyed Jennifer's concern regarding the lack of her parents' trust. Using the scaling technique as an intervention in the first session was appropriate and useful for a baseline; however, the timing of the technique needed to be taken into consideration. Waiting to search for

solutions after hearing complaints from all members would have resulted in a scale that focused on a solution and incorporated the viewpoints of all family members.

The technique conveyed information that was important to the client (Berg & de Shazer, 1993). This was evident by the parents' subsequent reaction and willingness to step back and take a look at how they were coming across in the upcoming week. For instance, they were able to be more flexible in allowing her to go out. They were also more cautious when they suspected drug use and did not overreact and accuse her. It is important to note that although the scale ended up being defined by what the parents could do to be more trusting, the issue of Jennifer gaining her parents' trust was revisited later on. Although the technique was helpful to elicit information, the pace needed to be slowed down, i.e. to address the issue of her parents searching Jennifer's room and incorporate her parents' reactions.

Case Management

In terms of case management the writer's role as case manager over this short-term period involved providing *direct personal support, short-term interventions, mediating* and *service co-ordination* (Frankel & Gelman, 1998 & McClam, 1998). Direct personal support was provided during several phone calls with the mother as she had many questions on possible symptoms and reactions to medication. This involved *mediating* back and forth between the nurse and the psychiatrist or other team members to provide information. On one occasion, Marie asked whether Jennifer's depression was related to thyroid problems. In checking the chart with other team members, the test results did not show this as a medical cause. The writer relayed this back to Marie. Another example occurred when Marie was worried that Jennifer was going to have a

seizure as a result of the medications. Upon consultation with the psychiatrist he advised that both medications were at a very low dosage making it unlikely that this would occur. The parents had previously rejected the full recommended dosage.

Short-term interventions included family therapy and individual treatment. Jennifer saw the nurse therapist two times a week for individual treatment. In terms of *service co-ordination*, one role of the case manager involved helping clients access services in a timely manner. The parents had many questions about the medication and diagnosis. The writer was able to ask the psychiatrist to come in and speak to the family during a session. This resulted in the parents accepting a more reasonable increase in dosage of medication for their daughter, which they were previously against.

The case management model worked well with the solution-focused therapy model in that the interventions provided different areas of service to clients. In the case management intervention, the family received quick access to the psychiatrist who provided further education on diagnosis and medication. The psychiatrist was flexible to consult with families in family sessions if deemed necessary. This is an example of a great benefit of case management in a multi-disciplinary team in the I.C.A.T.S program as it provided this family access to a needed service. The strength of case management in this situation was that it provided an important component in intervention by addressing issues around medication and understanding mental illness that was an important theme for the parents.

In contrast to the case-management intervention, the S.F.T. family intervention was beneficial in that it addressed the family environment. In team meetings, other members of the team commented that the mother was overreacting in many ways in terms

of her daughter's illness. Goal setting using solution-focused therapy was moving in the right direction in terms of helping Marie to control her reactivity and work towards increasing the trust level with her daughter. Jennifer's goal of building trust was an important one since it was a major theme of adolescence and under constant negotiation. Goal setting in a family environment using solution-focused therapy had its limits. Trying to address a goal for each person was too cumbersome. Selecting one major goal and each family member's viewpoint would have been more productive in a short-term family therapy setting.

Family Two

Presenting Problems

Clarissa Sanchez was a 17-year-old female who was referred to the program after discharge from the inpatient unit due to a near fatal overdose. Clarissa had a diagnosis of bi-polar affective disorder II (BAD II) and she had a series of suicide attempts since the age of 14. Bi-polar affective disorder II is commonly known as manic depression with a most recent episode of hypomania (American Psychiatric Association, 2000). Her last suicide attempt was extremely serious as it was very rare for anyone to survive the level of medication she had in her bloodstream.

Clarissa lived at home with her mother Alma and her older sister Louisa who was 19 years old and attending her first year in university. Clarissa's biological father had passed away when she was an infant. Alma remarried shortly after the accident and divorced when Clarissa was 8 years old. Four years ago Clarissa's stepfather moved to B.C. with her stepsister Kianna who was 15 years old.

Despite the family history, the issue of divorce seemed of little importance to Clarissa, as there are numerous stressors in the family. In Clarissa's family there has been a history of mental illness. Her mother was frequently hospitalized for depression and her older sister was beginning psychotherapy with a psychiatrist.

Alma was in a serious car accident 18 months ago and was preparing for a second surgery in a few weeks. Louisa took on most of the responsibility in the household and appeared more as a co-parent than a sister to Clarissa. Before the accident Alma had found employment and was gaining financial stability. After the accident, Alma did not feel she received fair compensation for the accident and the family has further struggled financially.

Alma discussed her aggravation with many other social agencies in Winnipeg. At the intake meeting, Alma talked about her anger towards Child & Family Services and was seeking help from the advocate's office to pursue a complaint. Recently Child & Family Services had visited to assess for family supports at the request of a community agency. The C.F.S. workers heard Alma say that she no longer wanted Clarissa to live at home. Alma denied the statement and Clarissa said she believed her mother. Sometimes details of Alma's frustration seemed peculiar in that these statements did not "add up".

Clarissa's service contract consisted of group therapy provided by the occupational therapist to help with social skills, and to attend family therapy. When asked about Clarissa's most recent suicide attempt in the first meeting with the family, Clarissa said she could not get her mother's attention as she was talking on the phone, so Clarissa took a lot of medications and went to sleep. It seemed that Clarissa's answer suggested impulsivity and lacked emotional congruence.

The family was seen for a total of five family sessions. Alma attended one session on her own and in one session the writer met with Clarissa and Louisa as a sibling subsystem. The primary theme in treatment was Clarissa's suicide ideation. Other themes included grief and loss over the car accident, Mom's concerns regarding her upcoming surgery, and emotional outbursts and abuse by Alma towards Louisa.

Solution-Focused Therapy

In meeting with clients who have had previous therapists Selekman (1993b) advises reviewing their experience so the same mistakes are not repeated. This also demonstrates the counsellor's interest in the family's future quality of service. The writer made this inquiry with the Sanchez family. Alma discussed how she appreciated therapists who listen and do not make judgements. Louisa discussed her reluctance to have to retell her story to new counsellors. Solution-focused therapy was seen to be helpful since the model does not require a thorough family history. Clarissa said she did not want to be told to move out of the home as recommended by her last therapist. This sounded odd since Clarissa was only 17 years old, and her apprehension was understandable. The writer asked Clarissa if she would be able to inform the writer if she was "off base" with suggestions, and Clarissa agreed to do so.

Goal setting occurred in the first session and explored the changes the family wanted to see as a result of coming into therapy (Klar & Berg, 1999). Alma and Louisa discussed their one main concern. They were both living under extreme fear that they were going to lose Clarissa to suicide. They both talked about going to bed at night and worrying if Clarissa would be alive in the morning. This echoed the trauma of the recent overdose. Currently Alma and Louisa had the medications locked up and would give

Clarissa a dose at a time. Alma and Louisa clearly stated they wanted Clarissa to live. Clarissa realised the impact her actions had on her family.

Reframing the term of suicide was helpful (Molnar & de Shazer, 1987). In a discussion with the family the writer normalized how there are times in adulthood when our lives become overwhelming and ending life sounds like a good option. The writer conveyed how suicidal thoughts did not mean that a person was going to act on it. The writer reframed suicidal thoughts of wanting to "end one's life" as meaning a wish for "the pain to end." During a follow-up conversation with Alma after termination, Clarissa was feeling low and told her mother she was not suicidal but just wanted the emotional pain to go away.

Pre-session changes (Berg & Miller, 1992) that occurred prior to the onset of family sessions were emphasized when the writer explored Clarissa's viewpoint in terms of being suicidal. She said she was no longer suicidal and wanted to live. Clarissa could not seem to elaborate on what changed her mind about her wish to live. Clarissa talked of her brain being "fuzzy" since the overdose, and she appeared sedated. The writer often respected her discomfort of not wanting to go into more detail. Her viewpoint represented a pre-session change, although what accounted for the change was not determined. Exploring pre-session change in this case was beneficial in that: 1) it addressed the positive efforts Clarissa made before treatment occurred; 2) Clarissa's viewpoint was given a voice and supported; and 3) the direction of therapy changed from helping Clarissa with suicide ideation to convincing other family members of her safety.

The "formula first" question was reviewed in the first session when the writer inquired into what needs to continue to stay the same in this family situation (Molnar &

de Shazer, 1987). The family was quick to answer the question and it was covered in the session rather than as homework. Both Alma and Louisa remarked that they loved Clarissa and wanted her to live. Alma talked about her daughters and gave them compliments by stating how she was jealous of Louisa's shiny black hair and how Clarissa maintained her figure. Clarissa said she wanted the family pets to stay. Alma discussed how she valued their time together. The family also acknowledged how they often laughed together even in the difficult times. The formula first session task was helpful in the first session, especially with families who have multiple helpers. It provided balance and prevented viewing the family as one with chronic problems.

One of Lipchik's (2002) principles of solution-focused therapy "nothing is all negative" (p.16) applied in a session where the writer met with the two daughters alone. The conversation veered into a discussion of their loss and grief since their mother's accident. Time was spent acknowledging their experience and the many changes that resulted. One big loss for both of the daughters was that they missed taking walks with their mother because she was no longer physically active. Afterwards the writer explained that sometimes good, in terms of clients' strengths, can emerge from difficult situations (Lipchik, 2002). The daughter talked about how this made them more capable and more independent. At the end of this session the writer inquired into what in the session was helpful. The daughter's commented that talking about the accident was valuable.

The scaling question was applied throughout the course of treatment during intervention and measurement (Berg & de Shazer, 1993). Scaling questions also look at the next step people can take to move forward (Berg & de Shazer, 1993). Alma

identified that she would like Clarissa to use the crisis phone numbers on the list the family had in the kitchen, or call a friend when needed. The writer asked Clarissa what she thought of this suggestion. She said she thought the request was reasonable. At the next session, Clarissa said she did not call any community resources because she did not feel she had a need for it. In terms of finding an option that would work to show that Clarissa could be trusted regarding her safety, Louisa remarked that only time would convince her.

In terms of measurement at the onset of therapy Alma stated she felt she was at a level of 1 out of 10 in terms of being assured of Clarissa's safety. Louisa stated she felt she was at a 3 out of 10. In applying the scale into the future the writer had asked what life would be like once they met their goal. Alma spoke to the relief it would bring and being able to sleep at night.

Scaling was revisited a total of three times before the end of treatment. At a discharge meeting at the end of the three-month period, Alma stated that she was at a level of 9 out of 10 in terms of being assured of Clarissa's safety. She no longer went to bed in fear. The writer asked what Alma noticed about Clarissa that made the difference. Alma referred to Clarissa being more in contact with her friends. Alma's confidence was evidenced by four days of medication being left out for Clarissa instead of a daily dosage. A week after the discharge meeting Alma called seeking a referral for Clarissa as her daughter was depressed. Alma said she was not worried about suicide since her daughter had told her, "Mom I'm not suicidal. I just feel awful." The writer asked Alma how she felt in terms of Clarissa's safety and Alma said she was still at a level 9 out of 10.

Case Management

Case management with the Sanchez family involved the following roles: *short-term intervention, service co-ordination, crisis management, direct personal support, tracking/follow-up,* and *broker-facilitator* (Frankel & Gelman, 1998). *Short-term interventions* included group therapy for Clarissa, which was provided by the occupational therapists, and family counselling. After a few family sessions, Clarissa and Louisa had planned to attend family counselling while their mother went into surgery; however, service was cancelled as they did not show up for appointments nor respond to follow-up calls. *Service coordination* involved facilitating another opportunity for Clarissa to try out another group since she did not find the first group fitting for her. As well, Clarissa was provided with an opportunity to attend individual counselling; however, she was reluctant to attend and did not follow through with making arrangements. Her mother Alma initiated requests for individual and group treatment; however, Clarissa did not follow through in accessing these services. This possibly indicated that Alma was more interested in getting treatment for her daughter than Clarissa was.

Case management tasks required shifting attention away from the identified patient and onto other family members. *Crisis management* was required when Louisa made threatening comments about wanting to kill her mother. This occurred after her mom stated to her that "you are an embarrassment and you disgust me" and walked out of a family session. In assessment, the homicidal risk was low, since Louisa said her statement was an expression of her anger and that she would not physically hurt her mother. Louisa's risk of suicide was assessed as low. She had some suicidal thoughts yet

was able to contract for safety. Time was spent in a family session exploring Louisa's pain as she only recently told her mother she dropped out of university seven weeks ago and was under a lot of financial pressure from overspending.

Another issue arose in terms of crisis management. Alma was concerned that Clarissa would be devastated when Alma went into the hospital. The writer asked Clarissa how confident she was in keeping herself safe while in the hospital. This question aimed at assessing into how the future would be handled (Lipchik, 2002). Clarissa stated she felt 100% confident she could keep herself safe from suicide while her mom was in for surgery.

Direct personal support was provided to Alma during a phone call she made to me after she walked out of a family session. Although she denied making the hurtful statement (above) to Louisa, the writer confronted her. Alma then conceded that maybe she made the statement and the discussion led to Alma talking about the abuse she had experienced in the past. After the conversation Alma was interested in reading information on emotional abuse (Mellody, 1989) and this was mailed to her .

Tracking & follow-up occurred at the end of the three month term as Clarissa needed another medication review due to problems with side-effects. It was an opportunity to follow-up with Clarissa and Alma, and to administer the evaluation tools. Clarissa turned 18 at the end of the three-month contract. *Facilitating* a referral to the adult system was not a straightforward process. Upon discussion with the psychiatrist, a referral to the adult system was to be made by her family doctor instead because Clarissa did not follow through with services in the I.C.A.T.S. program.

Summary

The solution-focused therapy model worked well with this family when goals were more immediate and clear for the family; for example, being assured of Clarissa's safety. Efron and Veenendaal (1993) acknowledge that solution-focused therapy works well for clients, particularly those who have "a clear definition of the complaint...[and] ...convey a strong change message" (p. 11).

Solution-focused therapy works with the strengths clients bring to therapy, and in this case, Clarissa seemed more assured of her desire to live. Exploring pre-session change was very important in the intervention as it validated the changes Clarissa had made. Acknowledging the positives in the beginning helped to build a sense of trust in the client-therapist relationship. The scaling question was useful in intervention and evaluation. Solution-focused therapy works well when families come to therapy with a clear idea of what needs to change (Efron & Veenendaal, 1993). The solution-focused perspective can be effective with multi-problem families by working on areas determined by the family, and it does not reinforce a problematic self-concept.

A major challenge arose with utilizing the model when the family was not ready to move into solutions in secondary areas, especially when negative emotions emerged. In getting to know the family over a few sessions, angry outbursts became more frequent. This occurred in one session where Alma was overwhelmed and took her anger out on her daughter Louisa. Louisa had recently told her mother she dropped out of university over six weeks ago. Alma was also facing surgery, and she was angry that her daughters were not helping out more.

In solution-focused therapy "focussing on the positive, on the solution, and on the future facilitates change in the desired direction" (Walter & Peller, 1992. p.10). Utilizing a solution-focused approach was difficult for the after the first solution-focused intervention went smoothly towards the first goal. In the above situation, the student struggled between finding a goal and moving into solutions. This family revealed more about themselves as trust was built in the counselling process and difficult emotions and conflicts emerged. Upon reflection, further acknowledgement of problems and negative emotions was needed before a new goal clarification process could begin (Lipchik, 2000).

One advantage of utilizing the case management model was that it offered flexibility and a variety of treatment options for clients in the adolescent mental health program. If one group was not fitting, second chances to try another group or treatment modality were offered in a short-term setting. In this case, a barrier arose, as the parent wanted her teenager to seek treatment more than the teenager did. Counselling in the I.C.A.T.S. unit treatment is voluntary for adolescents, as one cannot conduct therapy if the client does not want to participate. In this case, case management worked well in offering different treatment alternatives and in not pressuring the client into services she did not want. A corresponding principle of solution-focused therapy would support this intervention and would view the client as knowing her own direction rather than being resistant (Walter & Peller, 1992; Lipchik, 2002; de Shazer, 1984).

Family Three

Presenting Problems

The Van Dorn family consisted of Angela, a single mother, and her two fraternal 14-year old twin daughters, Donna and Deanna. Deanna was referred to the I.C.A.T.S. program from the inpatient unit with a diagnosis of major depressive disorder and parent/child relational problems. The family was on the wait list for treatment at the anxiety clinic at another hospital, so I.C.A.T.S. treatment was offered to help the family in the interim.

Angela and her ex-husband divorced five years ago. Angela's stepson Chad, 21 years, stayed with his father in Ontario. Angela and her daughters moved to Winnipeg to be closer to Angela's parents. Angela and her former partner were not on speaking terms. Angela remarked that the divorce was hard, but her former partner kept up to date with his child support payments. Donna and Deanna saw their father on the occasional holiday and for two weeks in the summer. Angela worked full time in an office while her daughters attended school. Donna had skipped an earlier grade and was in grade 8, and Deanna was in grade 7.

At the intake session, only Angela and her daughter Deanna were in attendance. Angela discussed many concerns in regards to Deanna's behaviours. Angela was primarily concerned with Deanna's rumoured dates with a 22-year-old male. Deanna denied this and yet could not account for why men would call the house and ask for her. Other themes covered over the course of treatment included school attendance, friends, sexual assault, running away, sibling conflict, and appointments with Deanna's probation

officer. Since Deanna was receiving individual treatment through another youth community agency, the contract consisted of family therapy.

The family was able to attend for eight sessions within a seven-week period. One session was spent with Angela alone, another with Deanna alone. Deanna and Angela attended some sessions together but Donna's attendance was sporadic. In the assessment process the writer met alone with Angela, and had another session alone with Deanna. Over the course of treatment some solution building occurred; however, serious problems arose in regards to Deanna's behaviours that placed her safety at risk and a case-management intervention was deemed necessary.

Solution-Focused Therapy

The solution-focused approach was utilized in this family setting. The following describes how the solution-focused intervention was applied in terms of reviewing past counselling experiences, goal setting, acknowledging positive changes, and the scaling question.

Past Counselling

Part of solution-focused therapy involves inquiring into past counselling experiences (Selekman, 1993b). Angela made a point that the counsellors would often focus on the relationship between her and Deanna, and leave Donna out. In this short-term intervention, Donna was not able to attend sessions because she would have missed out on tests, and on other occasions Angela was so extremely frustrated with Deanna's behaviours that the session only included the two of them. When Donna was able to attend family sessions her complaint that her sister stealing her clothes was addressed; however, some challenges arose in terms of goal setting.

Goal Setting

Deanna had begun to identify her direction near the end of a session that was spent alone with her in the beginning phase of treatment. The writer did not address goal setting until after a serious discussion about being sexually assaulted by an older male. This conversation led to the writer to confirm with the mother and Child & Family Services that the assault was investigated. Near the end of the session, the writer asked her about what her life would look like if it was moving in the right direction. Deanna replied that she would be doing well in school and dating a guy her age. Deanna's focus was on a future direction instead of the past, and there were challenges in bringing her goals into a family environment.

Not all family members wanted to build solutions together. Donna's complaint was that her sister would take her clothes without asking and return them in a ruined state. Donna wanted to pursue this as a goal, she said she was willing to share her clothes and make agreements with Deanna. In terms of exceptions (Berg & Miller, 1992; Walter & Peller, 1992), Donna talked of a time when they shared clothes and were upfront about the exchange. The writer invited Deanna into the conversation and asked if sharing clothes was something she wanted. Deanna said no. The writer acknowledged that an agreement could not be made at this time, and Donna explored what she could do on her own. She decided to lock up her clothes and this worked well for the next five weeks.

In a session alone with Angela, she did a lot of complaining and venting about her daughter's behaviour. Angela also remarked she was tired of coming to the emergency department on a regular basis because Deanna had too many crises. Deanna claimed to be addicted to cocaine for years, yet the R.N. in the emergency department did not find

tracks on Deanna's arms nor did a recent toxicology report find any traces of cocaine use. During the rest of treatment, Angela's focus revolved around crises that arose such as skipping school, sleeping in, missing curfew, or running away. In terms of goals, Angela discussed a new theme each week, and clarifying any one goal was difficult.

Later on in treatment, Angela was not able to move into a collaborative discussion until the third session. After a discussion of positive changes that occurred in a previous week, Angela was in a collaborative space and Deanna offered to agree to date a guy around her age category. Angela did agree to this and the writer suggested some caution. Angela and Deanna had a pseudo-agreement on a goal for the time being. In one of the last sessions; however, Deanna later told her mother she would no longer agree not to see older men.

Setting goals was a struggle using solution-focused therapy. Bringing the whole family together to build solutions can be a very slow process (Klar & Berg, 1999). Angela and her daughter had a pseudo-agreement. The dissolving of this agreement may have occurred for several reasons: 1) although mother and daughter were in agreement, the goal was superficial; 2) further exploration of past sexual abuse may have been needed before a goal was set; and/or 3) mother-daughter dynamics were strained and changes in the atmosphere were needed in order for Deanna to comply to any agreement.

Acknowledging the Positives

The solution-focused principle "change is occurring all the time" applied in this intervention in the middle phase of treatment (Walter & Peller, 1992). After the initial assessment sessions, the writer was surprised when Angela and Deanna came into a session with a lot of positives to comment on what occurred in the previous week. In

terms of dating older males, Angela told the man of Deanna's real age and he broke off the relationship with her. Angela talked about how Deanna was upset and crying. Angela showed empathy for Deanna and how difficult the break-up was for her.

In solution-focused therapy the counsellor needs to be careful in not moving too quickly ahead of other members (Klar & Berg, 1999). The writer made room to inquire into Deanna's perspective. She said she wanted to break off the relationship but couldn't. In the session alone with Deanna the writer reframed her Mom's angry perspective as an act of protection and caring. In the next session, Deanna reiterated that she saw Mom's act as caring for her, and that Deanna herself would not want her 14-year-old daughter seeing an older man. We explored future expectations (Lipchik, 2002). Angela understood that adolescent girls are not interested in boys of the same age, but said she would accept someone who was 14 or 16. From further dialogue, Deanna agreed to have her mother meet her boyfriend first before she went out with him.

When people talk about positive changes they are reminded of other positives (Walter & Peller, 1992). Angela was more relaxed in this session and talked about how Deanna was home when Mom called to check in on her. Also Deanna had spent time playing basketball with her sister. As well, Deanna listened to her mom and chose not to attend an evening event where people display their cars at the mall.

Using solution-focused therapy in a family setting has an advantage in that family members can reinforce and acknowledge changes that other members make (Klar & Berg, 1999). The writer asked what kind of difference Deanna's actions made to Angela. This was an opportunity to accentuate the positive to Deanna. Angela acknowledged that Deanna's actions made a huge difference in building trust.

Scaling

A scaling question was used with the mother and daughter as the writer used a whiteboard to make tracking visible to all. Angela said she was at a three out of ten in terms of trusting Deanna. The writer inquired retrospectively and asked where things were last week and Angela said trust was at a low level of one. This framework made it possible to make a positive inquiry of how things had improved. What made the difference for Angela was that she felt Deanna was telling her more of the truth. In terms of goal inquiry, Angela said she would be happy if things were at a seven to nine level. The identified factors included being trusted most of the time. Angela alluded to understanding her daughter's adolescence and didn't expect perfection. The task for the upcoming week was for Deanna to tell her mom about her whereabouts and be where she was supposed to be.

The scaling question was helpful in clarifying what Angela expected of Deanna. It acknowledged past efforts Deanna made as well. Upon reflection, this scaling question was quite one-sided, as it did not include what Deanna needed from her mother in order to achieve the goal. Goal setting was a struggle in the family environment when trying to focus on one goal for each person. The scaling question was challenging to apply. One important area of improvement was to explore what Deanna needed from her mother to make truth telling easier. In a family setting, solution-focused therapy includes, "what others can do to help and what can clients do to help themselves" (Klar & Berg, 1999, p. 256). In terms of helping this family who experienced high levels of conflict, more time acknowledging problems and emotions could have provided a stronger foundation to assist in building solutions.

Case Management

In case management with this family the *intensity* of contact ranged from moderate to high in the short-term *duration* (Woodside & McClam, 1998). Intensity was slightly higher in this situation as sessions occurred two times in one week during the assessment phase. Case management functions (Frankel & Gelman, 1998) included *service coordination, mediating* with justice agency, *short-term interventions, crisis management, providing direct personal support* and the *follow-up/ tracking role.*

Service coordination required accessing an increase in support for probation services and a medication review. Contacting Deanna's probation officer became a necessary task of service coordination. Near the end of the treatment term, Deanna showed up to family therapy after a rebellious episode. She was dressed very inappropriately for her age, wearing a revealing dress and high- heeled boots. After returning home from being absent without leave (A.W.O.L.) for a few days, she stated she no longer minded seeing her new male friend who was 26 years old. Angela was upset with the probation officer (P.O.) and felt he could do more in terms of checking up on missed appointments.

Service coordination involved getting Angela's permission to speak to the P.O. One unique aspect of working with adolescents under the age of 16 is that guardians can give consent without the youth's permission. Asking Deanna for permission would have probably been futile and Deanna would have declined. Deanna did not give permission in the intake appointment when the writer asked to speak to her counsellor at the youth agency. It was inappropriate to ask Deanna's permission if this was not a choice for her. Angela willingly gave consent to contact the probation officer. Deanna was aware her

P.O. would be contacted. Ethically, the preferred choice was to get Deanna's consent first; however, her safety level was increasing in risk and probably would have not consented.

In communication with the P.O., a *mediating* role occurred in terms of different approaches in treatment and the need for a systems meeting. The writer and the probation officer ran into a slight disagreement on approaches. The writer felt the mother needed to gain control as a parent, and the probation officer took the viewpoint that Deanna needed to make better choices. We both quickly recognized the futility of looking at who was right or wrong and agreed that both approaches were valuable. We were hoping for the same outcome for Deanna of attending school regularly and having a healthier lifestyle. Workers need to be careful not to compete over models and keep the focus on what is best for the client

Another outcome of the phone call was that the P.O. questioned whether he judged Angela too harshly. We planned to give the idea of a systems meeting more thought in terms of purpose and who would attend. Tim, the P.O. would run the idea by his supervisor and we would talk the next day.

The writer's thought was to hold off on the meeting, as the purpose was not clear and needed to be determined. We agreed to remain in contact if needed. The writer called Tim, the P.O., and his viewpoint was the same. He added that he and his supervisor decided to put additional supports in place by prolonging her probation period and by placing Deanna in the intensive support program, which meant Deanna would have daily contact with a worker who would follow-up on school attendance and evening curfew and conduct occasional in-home visits. The writer informed Angela of this at the

last family session. Angela initially reacted and she was not too impressed with this. She felt a daily phone call would not do much. After some discussion Angela decided to talk to the P.O. to find out more.

The second area of service co-ordination involved a medication review. In the last session with Donna and Angela, Angela explained that Deanna was much more bold since being on Paxil. This was significantly different from when Deanna was too shy to leave the house. The writer reviewed this with the doctor and R.P.N. since there could be a risk of an induced mania. To reduce the number of appointments for the family, a plan made for Angela to review this issue with the psychiatrist at the anxiety clinic with whom Deanna had an appointment in two days.

Short-term interventions involved only family counselling. Group therapy was not an option because Angela did not want Deanna to miss school. During the course of treatment Angela informed that Deanna was "dropped" from individual therapy by the community youth agency. Enrolling Deanna into individual treatment with I.C.A.T.S. was not an option because Angela did not agree to Deanna missing school, and Deanna was awaiting treatment with a new counsellor through the anxiety clinic.

Direct personal support and *crisis management* were provided to Angela throughout the interim. Angela called for support after an incident where Deanna was found with needles and other cocaine paraphernalia. The correct actions were taken as school principal contacted police and the emergency unit at the hospital examined Deanna. Deanna did not have tracks on her arms, although she stated that she had a cocaine addiction for years and wanted help. Another occasion occurred when Deanna went A.W.O.L. and Angela was provided with support as she informed missing persons

through the police and the probation officer. Another area where the mother was supported was in exploring options for placing Deanna in a group home. Angela had made appointments with an outside agency prior to I.C.A.T.S. and attended these with Deanna. Further support was provided on pursuing this option in case it was needed as a back-up plan following treatment.

Follow-up and the *tracking* occurred in the last session with Angela and her other daughter Donna. Deanna wanted to attend; however, Angela would not allow this since Deanna would usually be agreeable in counselling and would act to the contrary outside of the session. Donna and Deanna filled out the outcome evaluations. Angela commented that family therapy was not working for her in her situation because Deanna generally did not follow through with her decisions in therapy. In the last session with Deanna, she said she was not in agreement with her mother's goals and wanted to date a 26-year-old male. From Angela's verbal feedback and Deanna's behaviours, a decision was for a case-management intervention involving contact with probation services.

Summary

In this difficult case, the case management model provided an intervention when solution-focused therapy was not working. The intervention at the mezzo level included encouraging Angela to check out group home options, and advocating for more intensive support from the probation program. Deanna's behaviours of putting her life at risk by dating adult men, staying out overnight, theft from family, truancy at school, poor attendance at the probation office would deem this case as a severe problem (Miccuci, 1998). The case-management interventions aimed at parental control are supported when dealing with a severe level of acting out behaviours (Miccuci, 1998).

The solution focused intervention of exploring exceptions provided direction to further pursue the mandated resources. In exploring exceptions (Berg & Miller, 1992; Walter & Peller, 1992) of what worked in having an impact on this adolescent, the answer involved: fear of re-entering the youth centre and having an authority figure watch over her.

Treating the past trauma of Deanna's sexual assault was one area where both models had limits. In was inappropriate to pursue this issue in a family environment that included siblings as Deanna showed discomfort and embarrassment when her mother initiated the issue for discussion. Deanna was initially in individual treatment with another agency where this issue may or may not have been addressed. Deanna would not give permission for me to talk to her counsellor when the writer asked at the intake meeting. Child and Family Services were contacted to confirm the assault was reported. Solution-focused therapy can be effective in working with issues of sexual assault (Dolan, 1991); however, not in the confines of short-term case management and the instability of the parent-child relationship. Deanna was about to receive long-term services, and this would have been a more appropriate environment.

Using the two different approaches such as the case-management intervention along with a solution-focused approach was necessary. The solution-focused therapy helped in providing some progress with the family in the initial stages; however, more long-term support was needed. In a high-conflict family environment, more time acknowledging problems and emotions could have provided a stronger foundation to assist in building solutions. The case management task of consulting with the probation officer and advocating additional services helped Angela parent Deanna. A solution-

focused approach revealed that Angela felt Deanna was responding better to the discipline of probation services; therefore, an increase in probation services was the most logical step in this process.

Family Four

Presenting Problems

The Taylor family consisted of Jordan, 16, her brother Theo Jr., 8, and parents Janice and Theo. The Taylor family was referred to the program after Jordan was discharged from the in-patient unit. Jordan had a diagnosis of a major depressive episode. Janice and Theo were primarily concerned with their daughter's self-harm cutting behaviours. During the course of treatment Jordan had one acute incident where her parents worried Jordan could cause permanent damage or end her life. Janice and Theo had other worries related to teenage acting-out behaviours: problems with Jordan's honesty, curfew, increased alcohol use and contact with strangers over the internet. A secondary complaint of the couple centred on how they communicated. Theo complained that Janice spoke too vaguely, took too long to get her message across and would not portray situations accurately. Janice said she felt Theo put too much pressure on her to speak.

One strength of this family was that they were able to seek help when needed. They took advantage of the many services that were available to them. There were a total of eight family sessions. Jordan rushed from school and attended the last part of the first two sessions before deciding to drop out of family therapy. Janice and Theo attended six family therapy sessions together and Janice attended two on her own. Janice and Theo's schedules allowed them to attend the parenting group as well. Jordan was active in

counselling and attended individual treatment with a nurse therapist over the three-month contract. Jordan attempted to attend an occupational therapy group but dropped out shortly after it commenced.

<center>*Solution Focused Therapy*</center>

In solution-focused therapy, a family therapy approach can be done used with only one person (Walter & Peller, 1992). Solution-focused family sessions with the Taylor family did not include the whole family. The parents primarily attended sessions together and occasionally included Jordan or Janice attended on her own. In Selekman's (1993a) perspective, there is no such label as family therapy in solution-focused therapy since members are organized around the problem and are not organized around family units. This is unlike other family therapy models that require as many members as possible to attend. This model is flexible to meet the demands of the families. When working with families in which there is an adolescent member, much work can be accomplished with just the parents when the adolescent chooses not to attend (Selekman, 1993a).

In working with adolescents and their parents, adolescents can choose their own goal even if it is different from those of other members (Selekman, 1993a). This is fitting for the adolescent whose task it is to become her or his own person (Carter & McGoldrick, 1999). Even though Jordan rushed to the first session and attended only the last 15 minutes, the writer began to inquire what she wanted to see change as a result of coming to therapy. Jordan was very expressive and had many complaints. One complaint involved her feeling quite bothered about a comment her father made that Jordan "sought [individual] therapy to get drugs." After some discussion, Theo gave

more than an apology and sincerely took the comment back. At the end of the first session, Jordan said she was glad she came and felt more at ease. Therapy was worthwhile for Jordan in the first session as it addressed an issue important for her. Solution focused theory was used as it addressed a goal of the adolescent's choosing even though the process of amending the situation was not solution-focused.

Family therapy in solution-focused therapy focuses on problems initiated by clients and does not look at concerns imposed externally by the therapist even if family decisions are contrary to other norms (O'Hanlon, 1999). In one session Janice and Theo explained that Janice made all the parenting decisions so Theo could work on getting his business on track since being injured in an accident. The writer had considered how other models took the viewpoint that Jordan would be best served by a strong parental hierarchy (Minuchin, 1974). At this time Janice and Theo felt strongly about their position, and since both were in agreement about this, the writer did not challenge their position about how they chose to parent.

Couples can attribute past improvement in their relationship to the other spouse. This implies control may not be within an individual's realm. In the beginning stages the couple had talked of how their communication was better over the past week. An inquiry into what accounted for the difference quickly turned into a downhill argument about who had changed and who could take the credit for improved behaviour. The couple then quickly changed the topic and decided communication was no longer their goal. Solution-focused therapy questions were then ignored or dismissed by the couple.

In hindsight, one alternative approach to use would have been to ask questions from the other person's position (Walter & Peller, 1992). One example of this is "from

your spouse's point of view, what does he or she say that is more noticeable to you?" This question could result in some client resistance. This would require the therapist to acknowledge that her or his spouse noticed a difference, although it is not that different from her or his standpoint (Walter & Peller, 1992). Another option would involve acknowledging the anger or frustration of hearing one has changed, when it does not seem so (Lipchik, 2002). This could leave an opening to explore exceptions in the times when communication was easier as it was not a new experience for the couple, and thus could identify what made it so.

Recently more attention is being paid to the role of emotions and the timing of when to move into solutions (Lipchik, 2002). Techniques do not work as well unless salient emotions are addressed and the focus of solution talk too early in the process can lead to a meaningless conversation (Lipchik, 2002). In the latter part of therapy Janice revisited the discussion on couple communication. Time was spent acknowledging Janice's feelings of frustration and anger. The writer was able to keep the conversation on track by continually clarifying with the couple what was most important for them to discuss. Janice talked of her built up frustration. Her main concern was that Theo blamed Janice for problems in front of their children. This conversation led to the solution-building stage. This involved inquiring what actions Theo could take to help (Klar & Berg, 1999). Moving into solutions became a more natural and fitting step after Janice felt heard and chose the direction she wanted the couple to move.

Solution building with couples or family members is described in "interactional terms" where the focus changes from finding fault with the other person to looking for ways people can contribute (Klar & Berg, 1999). In the above example the writer asked

Janice what Theo could do to be more helpful. Janice discussed how she could tolerate Theo's strong need to blame others, but she wanted to be approached in private. After some discussion, Theo agreed to do so. The process of working with family members can be difficult and it "takes considerable patience and skill to draw the whole family system into a collaborative discussion of potential solutions" (Klar & Berg, 1999, p. 237). The use of this interactional technique appears to be very simple; however, there are contributing variables including timing and the role of emotions that lead to the effectiveness of the technique.

On occasion, the writer noticed solution-focused therapy accomplished the same objective as other models. In a structural approach the counsellor would have guided the discussion to address issues around boundaries and strengthening the parental unit (Minuchin, 1974). One asset of the solution-focused therapy model is the principle that it is the client who determines the problem and the pace of change, not the therapist (Lipchik, 2002). Janice was ready to make changes when she said she wanted to see Theo state his concerns in private instead of in front of their daughter. Paying attention to a client's readiness for change respects a client's level of motivation for change. When following a client's pace and direction, the areas clients choose to focus on are more appropriate and relevant to the context in which they live.

Case Management

Case management played a major role in intervening with the Taylor family. The organization-based model (Woodside & McClam, 1998) was well suited to this particular case as professionals from different disciplines within the hospital and the community assisted in *brokering* services to the family during the three-month period of outpatient

care. A nurse from the emergency department had referred the family to the youth crisis stabilization unit after Jordan had a severe self-harming cutting incident. Before leaving the crisis stabilization unit, a social worker from youth services had connected Jordan to an education program that provided her a home-based tutor who assisted in mediating with the school. As well, Tina, the R.P.N. therapist from the I.C.A.T.S. team (who was providing individual treatment) noticed Jordan was experiencing negative side effects and advocated a medication change through the psychiatrist.

Frankel & Gelman (1998) described the roles and responsibilities of the case manager that applied in this situation: in addition to *referrals* provided by others, the writer's case manager role involved *short-term interventions, educating* about other services, *providing direct personal support* and *tracking and follow-up. Short-term interventions* included family therapy and the parent group. The writer was able to provide information and *education* on the role of the youth mobile team. This occurred when Janice and Theo thought the youth service was only available for mental health issues. After the discussion, the youth mobile team was contacted to provide in-home mediation as Jordan tested limits and told her parents that she was not in agreement with her curfew and was going to walk out the door. *Direct personal support* was provided over the phone and in a session with Janice. On this occasion, finances were perilously low and the family was facing a food shortage the next day. The writer was able to reassure her that food was available through the food bank or through social assistance since Manitoba government policy ensures no person is to go without food. Fortunately, Janice received an unemployment cheque the next day. *Tracking and follow-up*

occurred in a phone conversation after the end of treatment where the topic was how the family was doing and evaluation arrangements.

Summary

The case management model complemented the solution- focused approach as case management is externally based and provides resources through brokering services. The solution-focused therapy approach is different in that it is internally based and relies on the internal resources of clients. Two clear examples of the conflict between relying on external resources versus internal resources occurred with this particular case.

The first example involved the parents' concern that Jordan was having a very difficult time reintegrating back into school after an inpatient admission. Using solution-focused therapy the writer took the approach of looking at exceptions of smaller change that leads to bigger change (Berg & Miller, 1992; Walter & Peller, 1992); Jordan was keeping up with her assignments and Janice was available as a support to Jordan by cell phone in case of a panic attack or any other problem that occurred. The internal approach of problem solving within the family was much slower compared with an in-home school tutor Janice located through another agency. The tutor was useful as she had experience and knowledge of working within the school system and in mediating conflicts, which put Jordan at ease.

The act of providing Jordan prompt and convenient access to a doctor for a change in medication was an example of how the case management model was preferred over the solution-focused therapy model. One principle of solution- focused theory is that "clients have the inherent strength and resources to help themselves" (Lipchik, 2002, p. 15). Medication can be a prominent factor in treating mental illness in adolescent youth.

In this case, the psychiatrist recommended medication as a treatment. Working with the family to rely on the teenager's inner resources for treatment of depression was contraindicated. Utilization of the solution-focused approach needs to be done with care. In terms of a solution-focused case management approach in mental health, medication is one possible solution in treatment allowing clients to "think more clearly" (Kok & Leskela, 1996, p. 399).

One advantage of using solution-focused therapy in this case was how treatment occurred even if other family members chose not to attend. Jordan's decision to stop attending family or group therapy was reframed as thinking about the solution in a different manner rather than as client resistance (de Shazer, 1984; Lipchik, 2002; Walter & Peller, 1992). As Janice and Theo sought family therapy and parent education they participated in the change process and sought treatment. Interventions in family and group work were reinforced in both modalities: the parents gained support from other parents for the work done in family therapy and vice versa, different and new material was provided by psychoeducation, and the parents experienced less isolation as a result of being with other parents. Some families may tend to see the adolescent as "the one with the problem." By attending family and group counselling, these parents sent an important message to their daughter showing a supportive and proactive stance towards their daughter's treatment goal.

Using solution-focused interventions and determining the pace and timing of interventions takes practice. Building solutions with clients can go very slowly. An example of this occurred when Janice and Theo chose to drop their decision to address communication and then revisited this goal later on. At times these clients were not

always ready to build solutions. Addressing emotions before solution building promoted client co-operation and led to finding more suitable solutions for the couple. Since solution-focused family therapy went very slowly, the case management model complemented the solution-focused approach quite well, especially in a short-term setting. The case management model approach gave the Taylors much needed access to services, such as the school tutor to help their daughter re-integrate into the community after her in-patient admission.

Family Five

Presenting Problems

The Jones family consisted of Marie, 37 and her two children Melissa, who was 17 years old, and Mathew, who was 13 years-old. Marie had recently left her husband who she was married to for 15 years and she became involved with a new partner. Marie and her ex-husband were currently renegotiating the real estate business they built together. High tension existed between mother and daughter. Marie was angry with her daughter for her suicide attempt and Melissa was angry at Marie's affair and choice of new partner. The family was referred to the I.C.A.T.S. program after Melissa was treated at the in-patient unit as a result of a suicide attempt.

Only Melissa and her mother attended intake and sought treatment. Melissa had a diagnosis of an adjustment disorder and parent-child relational problems. At the time when the family sought services at the I.C.A.T.S. program, Melissa denied suicidal ideation at the intake meeting and in family therapy sessions. Melissa was barely functioning in school and made arrangements to complete a manageable course-load for

the term. The service plan consisted of 1) family counselling for mother and daughter and 2) individual counselling for Melissa with the nurse therapist.

Marie and Melissa attended at total of eight family sessions; in one session Marie attended on her own. Setting up a primary goal and focus for counselling was established at the end of the first session. After reviewing the FAM III pre-counselling scores and an ecological map of Melissa's relationships, Marie was struck by the conflict and negativity in her daughter's life. Marie suggested improving the mother-daughter relationship and Melissa agreed. Over the course of treatment other themes were explored. This included Melissa's desire to move out, communication, Melissa's relationship with Marie's new partner Stan, and Marie's own survival of past trauma as a teenager.

Solution Focused Therapy

When applying solution-focused therapy, clients are the experts in determining which goals to pursue (Lipchik, 2002; Walter & Peller, 1992). In working with Melissa and Marie, Marie found her goal in therapy during the assessment. Teenagers can be difficult to draw information out of. Melissa was intelligent, yet would at times revert to a teenager vocabulary of vague comments and "I don't knows." In order to get to know Melissa better, the writer had her draw out an ecological diagram of her activities, the people in her life, as well as noting sources of conflict and sources of positive feelings.

Marie was shocked to find that Melissa had many sources of conflict in her life including their relationship that was described as both conflicted and positive. At this point Marie made a decision to improve her relationship with her daughter and chose this as her focus for therapy. Melissa nodded in agreement.

Improving the mother-daughter relationship was not directly centred on the problem of Melissa's diagnosis. This was in accordance with solution-focused therapy where the solution is not necessarily directly related to the problem (Lipchik, 2002; Walter & Peller, 1992). In working with adolescents and their families, Miccuci (1998) advises helping families to focus away from the symptomatic cycle (i.e. focus on life instead of the diagnosis). Marie's choice to work on the relationship with her daughter fit with solution-focused research (Lee, 1997) that indicated parents tend to choose goals in areas that includes them and where they have control.

Melissa did not raise complaints about adjusting to her parent's impending divorce; however, she had complaints about her Mom's new partner, Stan. Marie was undecided about her new relationship and the relationship was broken off and reinstated during the course of treatment. In one family session the details of the complaint statement were explored while Marie listened (Molnar & de Shazer, 1987). Melissa spoke of her anger towards Stan. In particular Melissa did not like how Stan teased her about sleeping in the garage in the new home. Outside of providing empathic support, no particular solution focused intervention was applied. This theme was revisited at the end of treatment when Melissa discussed that she was getting along better with Stan as the relationship had improved since Melissa was now working for his company part time. Marie added that she intervened by raising a concern with Stan about how the joke was hurting Melissa.

Exploring exceptions to the problem did not work as anticipated in therapy. Marie took her two children on a trip. Both mother and daughter agreed they got along better on the trip, but both were having a hard time recognizing which positive actions

could be replicated into their daily routine. Both Marie and Melissa felt the tension between them resumed as they came back home into their normal setting. Both thought that it was the men in their lives that led them to fight. This implied the control was not within their realm. Both complained of each other's choice of partner: Melissa thought Marie changed partners too quickly; Marie claimed Melissa was too young for a long relationship.

In trying another alternative, the writer examined the rules around the issue, which was similar to focussing on process over content, as well as de Shazer's concept of rules governing emotions (Miller & de Shazer, 2000). In this case, the implicit rule of who gets decision-making power in terms of selecting a partner became explicit. As a parent Marie felt it was ultimately her daughter who chose her boyfriend as Marie had the right to choose hers. Each other could provide comments; however, the individual made the decision.

Family competence needs to be supported since parents can get overwhelmed when their child is seeking treatment (Miccuci, 1998). As a parent, Marie had blamed herself at times. She referred to her past where she disagreed with her own mother's militant style of parenting and use of physical violence. Although time was spent acknowledging how Marie was a survivor of trauma, the writer inquired into the changes Marie made as a parent. The conversation changed from the extreme rigidity of her parents' styles and focused on how Marie made changes to her own parenting style. Marie emphasized one main point when she looked at her daughter and said, "Melissa has a mother who likes her and loves her." Marie had another parenting strength of setting consequences that were relevant; for example, her younger son made a fuss in the

store because he wanted an item and Marie chose to have her son do some yard work to earn it. Marie's past was explored in terms of building solutions into the present (Mittlemeir & Freedman, 1993).

Weiner-Davis (1992) explained that solution-focused therapy takes the perspective that insight is gained after an action is taken, which is unlike the psychoanalytic perspective that places an emphasis on insight before change. The use of role-plays can be applied in solution-focused therapy (Mittelmeier & Friedman, 1993; Weiner-Davis, 1992) to have clients try out solution- based options in order to gain understanding. In the sixth session the writer came prepared with the role-play exercise and chose to withhold the exercise and follow client direction. As a result, the writer noticed Melissa used "I statements" and tried to communicate differently with her mother. Eventually the conversation became highly charged and defensive from both sides and building solutions was still difficult. Upon reflection, the writer should have pursued the role-play earlier. In the next session, the writer was able to implement the exercise.

In the role-play exercise, both mother and daughter took turns playing the worst communicator, then the best, and finally trying out new techniques such as paraphrasing and "I" statements. Although Melissa was quick to dismiss its usefulness, Marie said she found it interesting. At a later session, Mom discussed her new insight and understanding. She remarked that she and her daughter used to have a lot of sarcasm and biting comments towards each other that seemed to get in the way of talking about the real issues. From a clinical standpoint, it was observed that both mother and daughter spoke to each other in a calm and less reactive manner. In this case, a role-play exercise

was useful in building solutions of communicating more co-operatively (Mittelmeier & Friedman, 1993; Weiner-Davis, 1992).

One principle of S.F.T is to change experience through interaction and that by changing its meaning the experience is changed (Selekman, 1993a; Walter & Peller, 1992). Family members can notice changes that the client may not be aware of (Klar & Berg, 1999). In one session the writer asked Melissa what were the changes she had made in her life since she began therapy. Melissa could not acknowledge any. In this conversation at 9 a.m. Melissa was not quite awake to clearly articulate changes; however, since Marie was able to, the experience was changed for Melissa. Marie was able to account important changes. She talked of how Melissa was less isolated, more physically active, and spending more time with friends. In a family environment, Melissa was able to hear from her mother that she was on the right track.

The scaling technique was used (Berg & Miller, 1992; Klar & Berg, 1999). At the onset of treatment the use of this technique was not as successful as compared with the end of treatment. In the first session, both mother and daughter had the same opinion that the relationship was strained 80% of the time. Marie complained of Melissa's attitude and yelling was a problem. Marie displayed these same behaviours. Attempts to talk about the 20% exceptions were highly futile in an emotionally charged atmosphere. At the end of counselling the Marie rated her relationship at a seven out of ten in terms of getting along. When the writer inquired into the higher rating, Marie explained she appreciated that Melissa invited Marie and Stan out to the cabin that belonged to her boyfriend's family. It was meaningful to Marie to be included into her daughter's life.

Melissa rated the relationship at a six out of ten and explained there were "less ups and downs."

The writer further probed into what accounted for the higher rating. Melissa explained that there were fewer arguments. Marie added that they both had sharp tongues and it helped to back off and co-operate more. The scaling question has different purposes, and in this situation was used to measure the client's viewpoint and extract information that was of significance to the client (Berg & deShazer, 1993).

Case Management

Case management with the Jones family involved a moderate level of intervention. Case management roles and responsibilities (Frankel & Gelman, 1998) included providing *service-co-ordination* with *short-term interventions, crisis management*, and *brokering/facilitating* referrals. *Service co-ordination* was standard and involved completing information for the medical chart such as the intake referral form and the treatment summary record that co-ordinated reports from other team members. *Short-term intervention* for the Jones family included individual therapy, family counselling and medication review. *Crisis-management* was provided when Marie was overwhelmed by many circumstances in her life and a suicide assessment was conducted. *Tracking* and *follow-up* was attempted with a letter sent to obtain an evaluation.

In the *organization-based model* (Woodside & McClam, 1998) Melissa received individual and family treatment in a short-term manner by two different team members. This model was advantageous as individual treatment and family treatment process validated each other. This occurred on two occasions: 1) when improving communication

and 2) when Melissa was trying to make arrangements to leave home. The writer noticed Melissa was trying to communicate better with her Mom by using less reactive talk and trying "I statements." Unfortunately, Melissa's attempts were drowned out by her mother's reactivity. This further encouraged the writer's decision to use the educational role-play. Family counselling gave Marie the skills to better respond to her daughter and enhanced the work Melissa accomplished in individual therapy.

The second example of how family and individual work supported each other was in providing educational services on referrals in an efficient and supportive manner. As a result of meeting every week or second week as a family, it may have taken longer to explore referrals on the issue of Melissa moving out on her own. Tina, the nurse therapist, spent time with Melissa on educating and exploring a referral to the independent living program through Child and Family Services. As a result of time spent in individual treatment Melissa later initiated a discussion in family counselling with her mother about leaving home, she was prepared with options to explore. Family interventions assisted in working through the conflict so Marie was more open Melissa's problem solving process. Since case management tasks were shared amongst the team, Melissa received greater support in obtaining access to services.

Sharing case management tasks in a team worked well when there was agreement on issues; however, incongruity can arise when members work from different perspectives. In the I.C.A.T.S. program, the psychiatrist and nurse therapist work mainly from a psychodynamic perspective, which can contrast with solution-focused therapy. Tina, and the writer had conversations on certain approaches with this case. She shared her viewpoint that Melissa may have come for family therapy in order to find out who her

biological father was so that she would be able to integrate more into the new family system. By utilizing a solution-focused goal that looked at how the mother and daughter improved their relationship, this helped Melissa integrate into the new family system as well. In the solution-focused approach, client pace and timing were respected. Mom intentionally told Melissa the name of her biological father in an initial family counselling session while writing out the family tree. Neither Melissa nor Marie initiated a conversation on finding Melissa's biological father in the course of treatment thereafter. The writer suggested this possibility Marie alone; however, she was completely against this. Working with team members who have different perspectives can be appropriate within the case management model. In this case, Tina and the writer were able to appreciate the different viewpoints rather than having to compete when using the different models.

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Summary

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There were strengths and limitations in using the solution-focused therapy and case management models in this particular case. Solution-focused therapy was applicable in many instances throughout the course of treatment. Solution-focused therapy was beneficial in a family atmosphere as Maria was able to validate the positive changes Melissa was making. Another benefit was that the strengths perspective could be applied to Maria who doubted herself as a parent when her adolescent entered treatment. The limits in applying solution-focused therapy occurred when tensions were high and the scaling technique could not be implemented very well. Addressing negative emotions and the timing of when to build solutions were factors in using some of the techniques with this family.

One criticism of the solution-focused therapy process is that it may have only partially, not completely, addressed the issue of Melissa seeking her biological father. Choosing a goal that was not problem oriented (improving the mother-daughter relationship) can be seen as ignoring the important issue of Melissa contacting her biological father. In a solution-focused therapy approach a client's lead is followed and they have control over the timing of when to address issues or build solutions. The writer had "tested the waters" and initiated the discussion with Maria in a session alone and from her reaction determined that this was a sensitive issue and the timing was not right. "S.F.T goes slowly" (Lipchik, 2002, p.18). Smaller changes lead to bigger changes (Walter & Peller, 1992). Improving the mother-daughter relationship could be seen as making a contribution towards laying a more positive foundation for discussing this sensitive issue.

Integrating other approaches with the solution-focused therapy model was useful. The educational role-play on communication was not a solution-focused therapy technique, yet role-plays share the common principle of modeling solutions. Including other tools in the assessment process made a difference. The ecological model helped to draw out a teenager who was not talkative in family therapy. This led her mother to not only set a goal but gave her the determination to work on their relationship. The results of the pre-test FAM III were presented to mother and daughter. Despite the problematic areas in the FAM III, the daughter was reassured that it was helpful to know that these were her concerns. Marie had found the FAM III interesting; however, she commented that some of the FAM III categories were vague and overlapped.

Applying the case management model was beneficial. Individual treatment sometimes provided intensive support of two sessions per week. The intensity of treatment and unique benefits of individual work complemented family work that took place every two weeks. As a student the writer questioned the impact of the two different modalities carried out by two different clinicians using different approaches. Although the writer observed there was less control over the therapeutic process, the work Melissa accomplished in individual treatment made her stronger for family therapy and vice versa. When the messages were the same, the work done in one modality, such as communication or exploring options to move out, was reinforced by the other modality.

Within the case management model, team members can utilize different approaches. This is beneficial if the messages are the same. Problems can occur if the client is given different messages by the two different therapists. Another challenge could occur if team members become attached to only one model and conflict occurs between members. When different approaches are valued, the counsellor has more alternatives to choose from. As a student, the learning from other team members such as Tina, made a positive contribution and enriched the writer's learning.

In this case, solution-focused therapy and the case management approaches complemented each other. Solution-focused therapy in a family session can go slowly, and getting family members to meet was challenging (Klar & Berg, 1999). This is disadvantageous if the client needs more attention in a short-term setting. Case management provided more options and access to different treatment modalities including the benefits of intensive individual therapy. In this case, the work in family and individual modalities reinforced or enhanced each other.

Family 6

Presenting Problems

Madeline Waters, who was 13 years old, had been referred to the I.C.A.T.S.

program from the neurology department after a stress-induced seizure, which was

medically cleared. She had no diagnosis nor did she take medication. One main concern

for Madeline's parents was that Madeline would cut herself on occasion. The last incident

was a month prior to the intake meeting.

Madeline attended the intake meeting with her father, Darren, and her mother,

Tracey. Darren was 43 years old and worked had his own carpentry business, Tracey had

an undergraduate degree in business and mainly worked in the home taking care of her

two children. On occasion Tracey helped Darren out with the books in the office.

Madeline had an older brother David, who was 15 years old and chose not to attend

family therapy. Darren and Tracey were attending marriage counselling, and Tracey was

receiving long-term treatment for depression. Madeline was also seeing a psychologist.

The contract was for family therapy only.

Attendance for family therapy was sporadic. Sometimes appointments were

cancelled and occasionally plans would change and only one person would show up.

There were nine sessions in total. Madeline and her parents attended the first session

together, Tracey and Darren attended one together, Madeline attended three on her own,

Madeline and her mother attended two sessions as a unit and Darren attended two on his

own. During the course of treatment the parents put couple counselling on hold with the

outside agency. Madeline also discontinued individual treatment in order to attend family

therapy. Time was also spent providing support to Tracey over the phone.

Several themes were addressed. One main focus dealt with Madeline's use of self-harm as a coping mechanism. Other themes included concerns of Madeline hanging around with much older male teenagers, the appearance of her teenage friends, conflict between the parents and Madeline, and the issue of how anger was dealt with amongst family members.

Solution Focused Therapy

In the initial meeting with the Waters family, the writer inquired into the area of family strengths in addition to looking at expectations for counselling. A modified version of the formula first session task was asked by inquiring what the family would like to continue to stay the same in the session (de Shazer & Molnar, 1987; de Shazer, 1985). The family struggled with the question and Tracey looked at Darren and she said, "Why is this so hard to answer?" The writer then broadened the question to include family strengths. These were recognized in order to provide a balanced assessment, and to avoid a problem based focus (Miccuci, 1998; Klar & Berg, 1999).

Both parents were quick to acknowledge strengths about their children. Both kids were doing well in school and had good grades and Madeline and her older brother got along well. The writer asked the parents about the strengths they saw in each other. Tracey remarked that she and Darren have become more open with each other and the kids. Darren agreed but Madeline disagreed. Madeline was quite tearful and anxious in the session and often talked only out of anger or in disagreement and could not answer the question. Darren remarked that Tracey loved the kids. Tracey said she trusted Darren, and he was helping out more with the kids.

Asking the question in the session may not have the same effect as having a client dwell on it over the week. Initially the family appeared uncomfortable in looking at the positives, possibly indicating that more time may have been needed to hear out complaints. When families struggle with this question in the future, it would be good to acknowledge the effort the clients were making to answer the question.

Teenagers who come to therapy to suit their parents are considered involuntary clients (Lipchik, 2002). In one session, Madeline's parents could not make it in and she was sent in alone. Madeline was not sure of what to talk about. She did not know why she was there and did not have anything she wanted to talk about. The writer acknowledged that her parents had sent her to counselling and that it was okay if she did not have anything ready to discuss. The writer then asked Madeline if she would answering a few questions and she agreed. After the initial pressure was taken off, Madeline was open to participating in the session and she was quite talkative.

In applying solution-focused therapy the counsellor pays close attention to meaning and interactions since "meaning and experience are interactionally constructed. Meaning is the world or medium in which we live" (Walter & Peller, 1992, p.24). The technique of doing something different (de Shazer & Molnar, 1987) was related to this theoretical concept since new options in creating exceptions can change a person's experience and the meaning behind it.

On two occasions the technique of doing something different strongly impacted the intervention with the Waters family (de Shazer & Molnar, 1987). In a session alone with Madeline we explored a recent self-harm cutting incident that occurred. Her intention behind the cutting was to send her parents a message. We brainstormed on

different ways for Madeline to send a message. Madeline's new coping plan involved telling her parents when she was tempted to cut. The technique was applied in context and was tailored to the uniqueness of Madeline's situation (Lipchik, 2002).

The second occasion of this technique occurred in a session when Tracey and Madeline were describing an argument over chores. The argument escalated to a point where Tracey grabbed the phone from Madeline's hands and Madeline insisted her mother hit her. (In a previous session alone with Madeline she had stated that her parents did not hit her or each other). Both Tracey and Madeline agreed this physical altercation was a one- time incident and was the exception and not the rule. In terms of settling if Tracey hit her daughter or just grabbed the phone, the writer acknowledged that both saw it differently and that we were not going to settle this argument. The writer emphasized how taking a physical step during a tense argument with teenagers would most often backfire. We looked at what could be done differently. Tracey suggested that if things were very tense she would walk away rather than have the situation get worse. The discussion then focused on doing something different around Madeline getting her chores done in a timely manner. The session focused on working out an agreement. As a result, Madeline agreed to give her mother a deadline of the time she would have her chores done by; and, Tracey agreed not to ask about the chores until the deadline.

Solution-focused therapy recognizes that the past cannot be changed; therefore, the focus is on the future (Lipchik, 2002). This was helpful in moving forward when Madeline and Tracey had different perspectives of what occurred when Tracey took the phone away from Madeline. It also helped to circumvent blame and shift the attention to issues that would likely reoccur in the future (i.e. dealing with tension and chores).

Exploring new and different alternatives to self-harm cutting incidents, avoiding escalating arguments and negotiating chores opened the pathways to change.

Klar and Berg (1999) explain how: "problems are constructed as one family member complains about the other" (p. 242). Other family members can reinforce problems; therefore, a shift in perspective is needed by the complaining members to confirm new changes (Klar & Berg). In a session with mother and daughter, Tracey was skeptical after hearing Madeline's coping plan when she would be tempted to cut herself. The writer reframed the skepticism, acknowledging Tracey was cautious to see if things would change. The writer further inquired about the difference it would make to Tracey if Madeline followed through. Tracey revealed a more positive side and remarked this would make a huge difference to her. This conversation could have easily taken a more negative turn if Madeline had thought, "Mom doesn't think I can change, why should I even try?" Two techniques have been very helpful in paving the way for solution building in a family environment: 1) reframing scepticism into caution, and 2) acknowledging the potential impact of new behaviours by other family members (Klar and Berg, 1999).

Making thorough use of exceptions to when problems do not occur is a fundamental component of solution-focused therapy. "Exceptions to every problem can be created by therapist and client, which can be used to build solutions" (Walter & Peller, 1992, p.12.) In the next session Tracey came into therapy and discussed how Madeline had taken some very big steps in the past week. After an argument with her mother Madeline went into her room after telling her parents she was very tempted to cut herself. After some thinking she went to her parent's bedroom, and talked to her father in an

honest manner about was upsetting her. Madeline smiled while her mother was talking about how proud she was. Mom remarked about how her daughter had shown a lot of maturity. In exploring the exception, we extracted the term "maturity" and identified the positive behaviours that included articulating her frustration into words. Exceptions, whether large or small, are important in S.F.T as they lead to identifying behaviours that work for the client (Walter & Peller, 1992).

A final aspect of applying solution-focused therapy in this case involved addressing the impact of negative stereotypes or labels in the treatment of adolescents and mental health. In a previous session Madeline's father said he wondered if Madeline was worried that she would become ill like her mother. During one conversation Madeline mentioned that she had to go to the "psycho-building" for treatment. The writer took this opportunity to explore her thoughts and feelings on this issue. Madeline explained that she wondered why she had to attend sessions over a three-month period while a friend of a friend only attended two sessions. Madeline thought this reflected on her personally. The writer explained the different types of treatment and how some people may not find it suitable or only attend for a few sessions for different reasons. The writer reframed and clarified that the length of treatment had nothing to do with her being more or less "ill" than others, and then further clarified she did not have a diagnosis, but came into treatment to deal with self-harming incidents of cutting and stress.

"Actions and descriptions are circular" (Walter & Peller, 1992, p. 26). This can refer to labels that can influence future actions. Using solution-focused therapy theory to change the meaning is to change the experience (Selekman, 1993a; Walter & Peller). Due to the fact Madeline did not have a diagnosis she questioned why she was receiving

treatment. In addressing the meaning of the negative stigma she may have internalized, a more positive outlook for Madeline was validated, which can impact her future experiences. Madeline's response was positive; however, her situation appeared mild compared to those of other clients. These questions could receive quite different answers and would require further intervention with teenagers who have severe diagnoses.

Case Management

The case management model played a role in intervention with the Waters family. As case manager, the functions carried out involved providing *direct personal support, short term interventions, brokering* and *facilitating* of services, and *tracking and follow-up* (Frankel & Gelman, 1998). Intervention in crisis management occurred through an outside agency during the course of treatment when the parents contacted the youth mobile unit to intervene due to a self-harming incident.

The *short-term intervention* included only family therapy since Madeline was seeking other therapy services elsewhere at the time of intake. *Direct personal support* was provided to Tracey on several occasions over the phone. Themes covered investigating possible psychosomatic symptoms, teenagers and drug use, and separation and divorce. During the course of treatment, Tracey was concerned that Madeline was vomiting and this did not appear to be caused by the flu. Upon consulting with the writer's supervisor Brad Brown, Tracey was referred to a doctor to rule out any medical causes. In terms of drug use, Tracey was quite concerned when her daughter talked of friends experimenting with drugs. Tracey was quite worried, although Madeline told Tracey she was lucky that Madeline would tell her about what was going on. Solution-focused therapy was used in terms of identifying client strengths, including Madeline's

very strong and vocal viewpoint against drug use. Other techniques included the fact-finding mission (Kirshenbaum, 1991), in terms of recognizing and validating Madeline's values stance and keeping the parenting "radar" quietly on to recognize signs of drug use.

In this case the writer did not *broker* referrals to other agencies as the family had supports in place; however, the writer provided educational resources. This made use of Tracey's strengths that included avid reading and ability to make informed decisions. One suitable article was a solution focus-based chapter written for clients that covered information on separation and divorce as Tracey was seriously questioning whether or not she should get a separation (Weiner-Davis, 1992). In terms of referrals, the family had services in place, Darren had sought individual treatment to deal with anger and the family sought services as covered by his benefit plan.

Tracking of progress occurred with Madeline in sessions and on the phone with Tracey. In sessions when Madeline did not have anything to talk about the writer took this as an opportunity to follow up on issues. In sessions prior to Madeline's self-harming incident she said she had not cut herself for a few months. In a session after the self-harming incident, and after the solution-focused therapy intervention, Madeline talked of how "cutting was a stupid thing to do." In a final conversation with Tracey after family sessions had ended she mentioned that counselling was useful in terms of helping Madeline with her self-harming behaviours. Follow-up steps were attempted in mailing evaluation forms to the family but these forms were not returned.

Summary

The combination of case management and solution-focused approaches had strengths and limits with the Waters family. This family had strengths in seeking help

when needed and were open to the views of several counsellors. Case management did not require work in terms of referrals. With this family, the solution-focused theory enhanced the case management model in terms of working with Tracey's strengths through educational resources provided.

One theme in case management involved the multiple therapists. During the three-month contract Tracey and Darren postponed couple therapy and Madeline dropped individual treatment for family sessions. Near the middle of the contract Darren began individual treatment to deal with his anger. Since solution-focused therapy does not require all family members to attend sessions, this model was useful in treatment by giving the family much needed flexibility regarding who would attend sessions. The option of having to spend individual time alone with Madeline was beneficial. This investment of time was important to the treatment process as Madeline found a coping plan for self-harm incidents of cutting. Another advantage of other treatment modalities was that the sessions easily maintained focus on parent and adolescent issues as other family issues were being addressed elsewhere. Solution-focused therapy was suitable for the short-term as it accommodated this family's long-term treatment goals and their personal schedule.

One disadvantage could have occurred if the counsellors had worked in different directions and given the client mixed messages. In several minor occasions Tracey was given different viewpoints by Darren's therapist and the writer. Using a client directed approach in solution-focused therapy, the writer followed Tracey's direction as she was contemplating a trial separation, and the writer gave her information to consider in terms of her choosing to separate. This conflicted with another therapist who, according to

Tracey, was against the trial separation and strongly suggested this couple should stay together to work out problems. The writer did not take an adversarial position against the advice of the other therapist that would put Tracey in an uncomfortable position. Sometimes clients misinterpret the messages of other therapists. The writer's approach was congruent with solution-focused therapy (Lipchik, 2002; Walter & Peller, 1992) and social work values (Kirst-Ashman & Hull,1999) in respecting the client's right to self-determination.

Final Analysis

Utilizing a solution-focused intervention within a case management model was productive in working with the families in the adolescent mental health population. In keeping with social work values of tailoring interventions to the individual (Kirst-Ashman & Hull, 1999), the solution-focused principle of "every client is unique" was applicable to both solution-focused therapy and case management (Lipchik, 2002, p. 14). Each of the six families required a unique intervention in some aspect of work with them; however, the same theoretical basis was used. In this practicum, the writer has increased her knowledge and skill level with solution-focused therapy and case management interventions. In the solution-focused approach, learning occurred through applying the principles of change, goal setting, scaling, and using these techniques within a family environment. Learning in case management involved co-ordinating services as each case had unique requirements. When used together, the solution-focused therapy and case management models met the diverse needs of clients.

Solution-Focused Interventions

Solution-focused therapy is a model based on principles of change. These aspects were quite useful in working with adolescent families in mental health. At times adolescents may feel *pressure to change*. Acknowledging the teenager's discomfort as the involuntary client was helpful in building a collaborative atmosphere (Lipchik, 2002). An example of this occurred in family six, where the teenager was involuntary because she was sent to counselling by her parents and she felt stigmatized receiving mental health services. At other times change was *not to be demanded* as clients were modeling their own solutions. Through the techniques of exploring pre-session change (Berg & Miller, 1992), finding exceptions (Berg & Miller, 1992; Walter & Peller, 1992), and the formula first task (de Shazer & Molnar, 1987; de Shazer, 1984, 1985), acknowledging the accomplishments clients had achieved promoted a sense of competence. Also, at times when *change was required* of family members the task of "doing something different" (de Shazer & Molnar, 1987) was quite a simple request yet powerful in helping clients to determine what new behaviours were needed. This was especially useful in family six that involved serious problems of self-harm incidents and disagreements that turned into physical aggression.

Goal setting in each family's situation occurred differently. In family two, members were very clear in what they wanted to see happen and goal setting was straightforward. This resulted in a solution building process where the techniques flowed smoothly. Goal setting also worked better in family five where one parent was quite directive in nature as goal setting was fitting to her personality. After collaboration she was quick to determine a goal.

In brief therapy there is the unrealistic impression of a one-session "quick-fix." A one-session intervention is possible when there was one clear goal within the family (Efron & Veenedaal, 1993). This was even possible in a population where families have extreme problems. The one-session short-term intervention is limited in situations when families want to address multiple problems.

In families one and three, goal setting was less favourable and more perplexing when an individual goal for each family member was sought. In family counselling in adolescent mental health setting, new themes can emerge in each session. This is also compounded by the challenge of goal setting, as it is not linear process with one starting point and one ending point (Lipchik, 2002). In family six where member attendance was very sporadic with different members showing up at different sessions, meaningful direction was found when the work centred around the main complaint in that session, and more so if this was related to the primary complaint at intake. A challenge arose in family three where not all family members wanted to work in the same direction, or on the same goal. Keeping to one main theme, incorporating each member's perspective whether or not there was agreement on the goal, and addressing emotions were key points to making goal setting more workable.

The scaling technique accomplished several purposes in the interventions and could be applied over the course of many sessions (Berg & Miller, 1992; Klar & Berg, 1999). This technique was useful in working with teenagers, and helpful to parents who gained a greater understanding of a teenager's perspective. This technique was less useful when applied too early, thus one person quickly dismissed the concept. As a clinician, this technique was helpful in collecting baseline information even if clients

were not ready to move into the solution building process. The scaling question was very practical in tracking outcomes for follow-up purposes. The scaling technique was more workable in a family intervention when the writer paid attention to the pace of each family member in terms of his or her level of commitment, and family interactions that included the contribution each member had made (Klar & Berg, 1999).

The limits of using solution-focused therapy in this setting were that more time was necessary to properly address emotions and to use the techniques with families. One option of addressing emotions and past trauma with the solution-focused therapy model was to allow clients to discuss the issue as needed and/or explore the past for solutions (Mittlemier & Friedman, 1993). For families in crisis, emotions can be under the surface and need to be addressed. Recent work (Lipchik, 2002) has restructured the model by encouraging a slower movement into solution statements and spending more time in assessment acknowledging the emotional impact of problems.

Applying the techniques in a family environment was another area in solution-focused therapy where direction from the model and supporting literature could be more enhanced. The direction that the same solution-focused techniques used in an individual session are applied in a family environment ignores the uniqueness of interactions in a family environment or a similar environment where people have an increased emotional investment. The resources on more comprehensive applications that pay close attention to family interactions have been very useful (Klar & Berg, 1999; Walter & Peller, 1992; Wiener-Davis, 1992). The example of using the scaling technique in a family environment has greatly influenced the writer's ability to apply these techniques in a family setting (Klar & Berg, 1999).

Case Management

In addition to the solution-focused family interventions, the case management model also provided valuable interventions. The primary function of the case manager was to provide service co-ordination within the I.C.A.T.S. program. Other roles of case management that were important in working with these families included: access to medical information from psychiatry, making referrals, and contacting other workers outside the agency. As a case manager it was easy to connect with a nurse or psychiatrist when families needed to address problems with medication, questions about diagnosis, or seek a consult if a client may need to be admitted into the in-patient unit. Another role of case management was to communicate with other workers in outside agencies (probation) to evaluate the direction of the intervention. Referrals were made to community resources when families wanted to continue with family therapy. Some families continued with long-term services that were already in place. A referral was not needed if the client was admitted into the in-patient unit, or the family had prior connections to an Employment Assistance Program.

Although the writer's role included providing solution-focused family interventions, other models were included as part of the short-term interventions. These other "tools" were useful when struggling to find the solution-focused therapy equivalent. The ecological map was useful with the teenage population and had multiple purposes: drawing out information when a teen was struggling with communicating verbally, communicating information to the parents; and for the clinician to keep track of people and activities in the teenager's life. The family tree was another way to keep up with the

names of significant members and was useful in terms of intervening as the mother in one family disclosed the name of a biological parent to her daughter.

Although solution-focused therapy was useful, it is predominantly a verbal approach and other models were needed in situations requiring non-verbal interventions. The eco-map was useful for teenagers who are visual learners. More "hands-on" tools like the ecological map are needed. What is important when working with clients, especially teenagers, is to find a way to get the message across in a way that the client can understand (Brown, 2003, personal communication).

Conclusion

The solution-focused therapy and case management approaches were more complementary than not, and especially in a short-term intervention with this population. One exception where the theoretical models did not come together occurred when services were involuntary. This occurred in one family where an "involuntary referral" for increased probation role was made to increase safety for an at-risk youth. For the most part, in this practicum, the case management role was important for providing families prompt access to additional support and resources while the family intervention, although a much slower process, worked at building support for the adolescent within the family.

CHAPTER FIVE - GROUP INTERVENTION

The second major component of learning in this M.S.W. practicum experience involved designing, setting-up and implementing a psycho-educational parenting group for the I.C.A.T.S program. There are many theoretical models that describe different stages of group development (Toseland & Rivas, 1998). The following will illustrate the parenting group intervention through a discussion of the phases of group development in four all-encompassing categories: 1) the planning stage, 2) the beginning stage, 3) the middle stage and 4) the end stage.

The Planning Stage

Implementing a psychoeducational group involved a lot planning. The planning phase starts at the group's conception and can overlap into the middle and end stages. Will (1999) advises of the following tasks in setting up and running a family education program:

- Assign responsibility for the program
- Administrative support
- Preplanning
- Survey families
- Conduct literature search
- Determine goals
- Consider population and setting
- Determine length of program
- Select content and topics
- Recruit presenters
- Design brochure
- Advertise
- Select program facilitators

- Train facilitators
- Recruitment of families
- Start program evaluate (ongoing)
- Be flexible and adaptable
- Update information
- Be open to change (p. 298)

The following describes the planning process of the parenting group using Will's tasks (1999) as a basis.

Preplanning

Designing and developing the group became a negotiated and creative process amongst the team members and myself. In the initial stage of negotiating my practicum placement a decision was made that the writer would develop the parenting group. Co-facilitation of the group would be shared with a nurse from the team. A decision was made to ask parents about expectations of the group in the first session. Since parenting groups can differ amongst populations, agencies and program objectives, preparation of group content was guided by theory and also through consultation with the I.C.A.T.S. team members.

Group Goals & Content

The goals of the parenting group were as follows:

1. To differentiate between behaviours of mental illness and adolescence.

2. To educate about and promote support for developmental tasks in the family life cycle stage of adolescence.

3. To promote respect in the parent-teen relationship.

The selection of group content occurred in different phases. Initially a meeting was held with team members to discuss the different components that would be relevant for parents in the context of the I.C.A.T.S. program setting. After much research the agenda was set and a review meeting was held with my practicum supervisor, Brad, and two nurses from the team, Marlies and Lisa, and the writer to verify that the agenda would fit the outpatient hospital setting. The content, topics and exercises fit into seven weekly sessions. Initially, each session was to be one hour in length with the first 20 minutes containing a power point slide presentation.

The material in the first session contained medical content; and therefore, was presented by the nurse. Plans were made to bring a psychiatrist for further discussion if needed. Although most psychoeducational groups can be homogenous, including members who deal with the same symptoms and diagnosis, the referral numbers could not support a homogenous group with a common diagnosis. Group content addressed mental illness on a continuum to suit group members who had teenagers who were dealing with different symptoms.

Much of the psychoeducational group content was presented in a slide presentation. Much time was spent selecting material, narrowing down the topic and editing the information to make it understandable for the general public. Editing the information continued until the presenting day. Before each session the co-facilitator and myself reviewed the upcoming presentation. The first session included information on orienting members to the group. More detail on group rules will be covered further in this chapter (see "group norms"). An outline of topics was presented at the beginning of each session (see Appendix N).

Group Recruitment

Initially, all parents were recruited from the I.C.A.T.S. program only. Ideally, the writer had hoped the group would start with 8-10 people (including multi-family units) and anticipated that a few people would drop out along the way. Families were informed of the group at the intake meeting and given a brochure (See Appendix L). Other members of the team were given brochures to hand to clients who were already in the program. In order to increase the referral base, permission from the hospital administrator was sought in order to open the group to parents who were part of the long-term outpatient child and adolescent program. Will (1999) advises interviewing members ahead if time to determine what they would want from the group. Interviewing the parents ahead of time was not feasible due to the challenges with recruitment. A pre-screening of participants occurred at family intake meetings and through referrals by clinicians in the O.H.M.S. program. Furthermore, an inquiry into the expectations of parents occurred in the first session with participants.

Recruiting enough families in order to start the program had many challenges. The time of the group was a factor for a lot of families as the group was held between the hours of 8:30 a.m. to 4:30 p.m. In initial intake meetings some parents mentioned that an evening group would have been more suitable; however, this was not negotiable because the group needed to remain within the working hours of the team members. Plans were initially made to hold the group at the end of the working day at 3 p.m. so parents could leave work earlier. Another challenging factor for parents involved fitting services into their schedule. Making arrangements to get a family together for family therapy *in addition to* group therapy is difficult for many parents who work.

Due to certain challenges with recruitment there were a few false starts along the way. The initial group start date was postponed two weeks as numbers were low. The session time was changed from 3 p.m. to 9 a.m., in order to accommodate parents who worked evenings. The second start date for the group was cancelled one hour before it was due to start as one person dropped out and another cancelled, leaving too few members for the first session. It became difficult to postpone the group for members who had made plans to attend and two people were not able to attend on the third start date. In order to increase recruitment, referrals were sought through another outpatient unit that provided long-term service. This involved getting permission from the mental health program administrator, meeting with members from the Outpatient Mental Health Services team, co-ordination with O.M.H.S. case managers for referrals, and contact with individual clients.

Co-Facilitation

The group had two co-facilitators for each session: the writer and a nurse from the team. One aspect in the reality of work conditions is that some nurses work part-time and job-share. For the group, this meant that the nurses, Lisa or Marlies, attended alternate weeks in facilitating the group. At first the writer was apprehensive about how this would affect group cohesion. In problem solving with the nurses, an agreement was reached where both nurse facilitators would attend the first session and the facilitation arrangements would be explained.

Every week the nurse co-facilitator Lisa or Marlies and myself met for an hour or so to review the material for the upcoming week; for example, selecting scenario examples and discussion of role-plays. At times the content or examples were modified to

better fit the parents' situation. Part of group planning involved meeting with a group

counsellor of the parenting group from the Addictions Foundation of Manitoba for

consultation. The nurse co-facilitator Lisa and the student received feedback on the

materials we were developing in regards to the tougher issues of dealing with adolescent

alcohol and drug use.

Starting the Group

After cancelling the start date twice the group commenced on the third date. A

decision was made to start the group with five members rather than postpone the group

and lose new recruits. One couple had planned to alternate weeks where the husband

attended one week and his wife attended the next. The first session began with four

parents: the husband of the couple who were switching weeks, one single mother parent

from the O.M.H.S program, and one couple from the I.C.A.T.S. program.

In the beginning the writer was uneasy about the small size of the group. One

advantage of working in a hospital setting is the opportunity to see the process of other

groups. For example, the occupational therapists who work with adolescent groups on

life skill development regularly run two groups in a week. On occasion some groups start

with eight people and disband in a few sessions. Some groups can run continuously with

three or four people. In starting a group one has to be flexible and open to change (Will,

1999). A small group setting did not seem to be in sharp contrast to other on-going

groups.

Setting

The group room and the setting at the hospital were quite conducive for group work.

Coffee was ready for parents for the 9 a.m. meeting. The room had appropriate

adjustable lighting and was a comfortable size for the five members and two facilitators with a flip chart and a computer projector. The use of the computer slide presentation dramatically affected the how the material was presented. The slides provided a clear visual of the concepts presented and kept group discussion focussed.

Evaluation

One final aspect of the planning stage involved the evaluation of services. A decision was made to use only one measure, the Client Satisfaction Questionnaire –8. Other standardized measures were considered; however, significant change was not expected after the parents attended a psychoeducational/information session. Written and verbal feedback from the participants was used to consider planning future group sessions. The C.S.Q. – 8 (Larsen, Attkisson, Hargreaves, Nguyen, 1979) was modified to fit the group context. Individual items were modified to ensure the questions reflected the group service instead of other services clients were receiving. Other items were added to inquire into member's feedback regarding group content.

Summary

The planning stage of a group starts at the initial stages of group development, and it continues throughout the entire group process and overlaps with the other stages. In this group, planning involved fundamental tasks as well as responsibilities unique to the hospital setting. This included limiting recruitment through case managers and working within administration guidelines. The next section discusses the beginning stage of this group.

The Beginning Stage

This component will focus on three prominent issues of the group in its beginning stages. One issue involves the impact of the heterogeneous composition on the group. The other two issues –group norms and group cohesion- are important to review as they influence group development and growth (Shives, 1998).

Group Composition

Selecting family members on the basis of a homogenous population was not possible due to the small list of recruits. The group composition consisted of five members, which included two couples. A description of the members is provided below.

Group Members

Maria, a woman in her forties, was a single mother. Her daughter was 13 years old and dealing with anxiety that was prohibiting her from participating in school and making friends. Maria's family was receiving treatment in the long-term outpatient unit.

Terrence and Nicole, ages 46 and 41 respectively, have been married for 16 years. They have two daughters aged 15 & 12. The couple has attended family counselling for approximately 1 ½ years in the long-term outpatient unit. Their oldest daughter was struggling with self-harm cutting behaviours and did not have a diagnosis. This couple had originally planned to alternate weeks in attending the group.

Mark and Linda, aged 44 & 41, had two children: a daughter who was 14 years and a son, Michael who was 8 years old. The couple was referred from the short-term intensive treatment program as their daughter had a diagnosis of major depressive episode and had difficulties attending school. In addition to the parenting group the couple attend family counselling on a weekly basis.

The group was heterogeneous as each parent's daughter had a different diagnosis. This group had similar characteristics in that all parents had a first born in the middle age group of adolescence (13-16 year old); therefore, all families were near the recent transition of entering the adolescent parenting phase of the family life cycle. The heterogeneous composition of the parenting group had the advantage of helping parents to focus on parenting issues surrounding adolescence instead of their child's illness. Chazan (2001) described the merits of heterogeneous group composition, "When the diagnoses are mixed, there is a good chance the focus will be on the dynamics of the whole family, which are important whatever the diagnoses (p. 152)."

The heterogeneity of the diagnoses also raised challenges in terms of developing group content for the session on mental health. The plan was to cover the topic of diagnosis, treatment and medication in a broad manner. The concern was whether or not this would suffice for the parents. The exercise involved asking the parents to identify symptoms on a continuum and indicate what was normal angst and what was not. The parents engaged well with the material and the exercise. There was no need to bring in a psychiatrist to further answer questions as planned. Feedback from the evaluations and observations of the co-leaders and the writer was favourable. Covering an overview of major diagnoses worked well since it normalized behaviours found in all individuals and addressed a variety of symptoms. This provided additional and relevant material for parents since they found their teenager could have a diagnosis of depression and yet still experience anxiety.

Group Norms

Group norms are the "standards that govern behaviour of the group" and refer to norms such as commitment to attendance, confidentiality, and expectations around disclosing information (Corey & Corey, 1987, p.120). Group norms can be explicit or implicit. A small list of group rules was presented at the start of the first session. One rule, the commitment to attend each session, was emphasized since attendance is important for members as they learn from each other. Other rules focused on the discussion. Members were asked to keep on topic since time was limited. In terms of disclosure, members were asked to share only what they felt was comfortable to their own public/private boundary.

Recognizing that parenting decisions are laden with personal and cultural values, a point was made to acknowledge differences in values amongst parents and the facilitators asked that differences of opinion be respected. Adolescence is also a time where the teenagers are developing their own value system. Respecting differences between members serves as learning that can be carried into the parent/teen relationship.

Some norms were developed as the group proceeded. The planned one-hour time limit was another area that was open to group change. Around 55 minutes into the first session, a lot of material remained to be presented. As the writer looked around, the body language of members signalled that they were quite engaged in the group. At this point, the writer made a decision and explicitly asked the group if they were willing to stay another 30 minutes. Fortunately everyone was able and willing to stay. If this had not been the case, the group could have wrapped up. Making the time change explicit may have prevented conflict.

My co-leader's experience showed me the value of being able to follow the group lead when necessary. The discussion got well under way after the introductions of members. My co-facilitator took the initiative and began the group exercise that asked parents to identify adolescent behaviours on a continuum distinguishing those that were part of normal adolescence and those that were considered mental illness. A decision was made to leave the presentation of the slides for the end. Showing the slides at the end of the session was valuable in that it reinforced the parents' knowledge that they had shared and learned. From this first session, each session format was changed. An exercise was generally held at the beginning of a session to encourage discussion on the topic. The educational slides were shown at the end as a reinforcement of member knowledge. Without the guidance of the co-facilitator, the writer may have not been so open to follow a notable change.

Group Cohesion

Group cohesion refers to the level of trust members have of each other; for example, the level of acceptance of disclosing comments (Corey & Corey, 1987). The highly structured format of the group contributed to group cohesion. A less structured group can increase anxiety for members in the beginning stage (Corey & Corey, 1987). Another contributing factor involved the lack of pressure for members to step in and take ownership of the group; members could participate according to their own comfort level.

Group content can greatly influence group cohesion. "Group attractiveness and cohesion are related; it is generally accepted that the greater the degree of attractiveness of a group to its members, the greater level of cohesion" (Corey & Corey, 1987, p. 124). Adolescence is a remarkable stage in the family life cycle that has many sources of

pressure for change in the family (Carter & McGoldrick, 1989; Olson, 1993). Also, many parents question their parenting ability when a teenager has entered the mental health system for treatment. Our group focused on mental health issues and adolescence and these topic areas were quite appealing to particpants. Parents quickly engaged with the material and were willing to open up about their struggles. One husband of the couple who initially chose to alternate attendance with his wife changed his mind in the first session. He stated he would be back for the next session with his wife.

Although the high structure of the group promoted group cohesion, there was still a need to address group dynamics. Encouraging quiet members to comment in order to avoid one member dominating the discussion was needed at times. Comments made with humour or in a non-threatening manner to acknowledge to members that the discussion was getting off track helped to keep group focus. Addressing body language was important. Asking members who showed a questionable frown or deep silence to speak or share a different viewpoint enriched group content.

In promoting group cohesion, leadership can be shared and taken over at times by various group members (Corey & Corey, 1987). As co-facilitators, a point was made that parents know their child best and we did not have all the answers. We often paid careful attention to the strengths and wisdom parents brought to the group. For example, one common theme that arose dealt with teenagers and how they try to split the parental unit. One member discussed how he and his wife have an agreement that "if you start it, you finish it" and the other parent is to back up the decision despite contrary feelings. Members often learned from each other and the educational material became secondary at times.

The Middle Stage

The parent group shifted from an educational focus to a dominant support focus. As a result, group dynamics were emphasized. The following section discusses the prominent features of the middle stage: co-leadership issues, group resistance and group dynamics with families.

Co-Facilitation

Working with the same co-facilitator can make a difference to group cohesion. Leading the group with other members of the team was beneficial in some ways. As it worked out, one co-leader was ill in the third session; therefore, my supervisor Brad stepped in. As a result, the student worked with three different leaders in the first three sessions. The group members were kept well informed of the changes in an effort to avoid confusion. The members did not comment about these changes, and in the evaluation, it was not mentioned. Upon further reflection, this would have been a good area to probe into in the evaluation. One benefit of having different co-leaders is that different presenters keep presentations more interesting.

The experience of working with different co-facilitators was not as difficult as expected. The group did not have a dominant psychotherapeutic growth focus; therefore, members' engagement with leaders in an educational format was not as imperative. As a student working with three different co-facilitators, the writer saw different styles of each co-facilitator. As a student and co-facilitator, the writer found a benefit in working with the nurses who alternated facilitating sessions. One nurse was more inclined to lead and the writer learned from her skill level. Another nurse was more inclined to have the student take the lead, which required the writer to take a more directive role. In the one

session where the writer co-facilitated the session with Brad, the writer had the opportunity to see his natural tendency to focus on process over content with parents. It is also worth noting that Brad stepped in to co-facilitate the group at the last minute for a co-worker who was ill; this coincidence resulted in having a social worker co-facilitate the session on family characteristics. This was very fitting to the social work outlook that addresses the person-in -environment perspective.

Co-facilitating the group had advantages over a group with one therapist. It was helpful to take a "tag-team" approach. When one leader had difficulty with the discussion the other stepped in. Planning and debriefing of sessions is easier with a co-leader. Working with co-facilitators from a different discipline was particularly helpful as the nurses were able to prepare and speak to material that contained medical content for the first session on diagnosis, medication and treatment. Another advantage is that co-facilitators can step in and defuse potential alliances from occurring with group members (Chazan, 2001).

Group Resistance

Part of the working stage is characterized by working with member resistance (Toseland & Rivas, 1998). The co-facilitators and the writer encouraged and conveyed a message of respect for member disagreement with us, the material or other members. For the most part this message was given and modeled; however, there was a more challenging situation that is worth noting.

Linda, the wife in one couple, came into session five with little eye contact and was noticeably disgruntled. She did not respond to welcoming comments from the group and could have had anger towards the co-facilitators or the other members. The writer opened

the session with a round robin check-in and inquired into difficulties members may have. This gave Linda permission to share negative comments.

Linda engaged quickly and described her difficulty as her daughter was challenging the consequences the couple were trying to put into place for breaking her curfew. Linda felt this issue and other acting out behaviours were getting worse. Linda and her partner acknowledged the need for the group to stay on topic and vacillated between revealing more of their situation and not wanting to go into further discussion. When a couple brings a crisis to the group, a challenge exists for the worker to facilitate the crisis or continue with the planned exercise. For the writer, this turned into a struggle with group norms. An earlier message had been given that the group had an educational purpose and if members had a difficulty with the content it could be further explored in-depth with their family therapist. During the check-in, the couple decided to not talk about the issue in order to allow the group to continue.

The writer introduced the exercise "Treating Family Like Friends" (Metcalf, 1998) and acknowledged how it was ill timed for this couple's situation. Linda spoke about her problem in the ensuing discussion; however, the issue was not resolved for the couple. Linda remained withdrawn and unhappy for the remainder of the group. At the end of the group the writer asked Linda if it would be helpful to talk later in the day by phone and she accepted. By phone, the couple and the writer talked through the problem and the couple regained control and settled.

Upon reflection, other options exist to deal with a crisis in a structured group process. One option was to openly set time aside to further explore the issue where the couple could request group feedback. Another option is to respond and show appreciation to the

couple for putting the group's needs ahead of their own. Finally, the writer could have asked to make arrangements to discuss this issue outside of the group immediately after the problem was identified.

Group Dynamics with Families

Having family members in the same group can impact group dynamics. This group was not a couples' group since a total of three couples were needed and this group did not have a dominant focus on couple interaction. As the middle stage of the group mainly consisted of two couples, this composition provided great value to my learning as the writer could observe the effect on group dynamics.

Chazan (2001) points out that recruitment is more difficult for couples; and the alternating couple routine may serve as a defence against conflict. Group dynamics with the same family members provide a different learning experience compared to a regular group whose members are not related. Instead of the individuals providing feedback to another member as individual members, family members can gain feedback on their relationship dynamics as well. The emotional stakes are higher and the group is more intense for family members.

Four different dimensions of a couple or multi-family group are described by Chazan (2001):

1. Zero or no dimension: the psyche of the individual member.

2. The second dimension takes place at the intra-couple level.

3. The third dimension involves intervention on an intra-group basis that has many aspects: one individual's perspective on an individual, on a couple, or the group. At the couple level the intervention can include a perspective of

how a couple can view itself, one member, or interaction between couples, or a couple's view on the group.

4. In the last dimension, intervention is between the therapist and the group.

Chazan supports interventions that involve more focus on the last two dimensions than on the first two since feedback coming from group members can be more valuable and less like individual couple therapy (2001). The main objective of the group was to provide parenting skills and was not a couples' therapy group; however, multi-family dynamics existed. Nicole, the co-facilitator was quick to ask Mark and Linda how long they had been in therapy. Nicole had identified with the couple's conflict and provided encouragement for the couple to stay in family counselling. She added that after a year and a half of family treatment, she and her husband could support each other better. Nicole had provided the other couple with an outside perspective. She also acknowledged to herself and to her husband the progress they made. Thus she intervened on the first three dimensions: intra-psychic, intra-couple and intra-group.

One advantage of recruiting group members from both hospital programs (the short-term intensive unit and the long-term unit) is that group members can complement each other. The give and take is shared and members who have more experience can provide a mentoring-like relationship to those who were new to the mental health system and have more to learn.

Conflict between a couple can be an issue for members and can be dealt with in many ways. One of my co-leaders asked a couple to "shelve" the debate and to continue another time using humour. The other members smiled and acquiesced while the debating couple laughed at themselves. Chazan (2001) points out that members may try to control

each other and monitor what the other is saying. This could also be an advantage if one member is talking too much and they respectfully keep each other in check.

In this group the writer experienced the opportunity to work as a family therapist and group leader at the same time. From this vantage point, the writer observed how the two interventions worked together; for example, new language obtained from the group was used by members in the family session. Also, Mark and Linda reinforced messages that were made in family sessions. Problems could occur if work from the session unnecessarily addressed problems that needed to be dealt with in the group. Another advantage of the group involves the lessening of the therapeutic alliance that can happen in a family session. With co-leadership, leaders have a tendency to appear less aligned with one spouse in a group than an individual therapist in family therapy (Chazan, 2001).

The dropping out of members may have also been influenced by dynamics of multi-family groups. One member left the group due to personal reasons; however, this member was single and the only single parent with two couples in the group. She did not cite this as a reason but for someone else this could have been a factor. Another father from one of the couples dropped out of the group after the fifth session. Couple conflict appeared to be a factor. The reason for this was not made clear and the group respected his wife's decision not to address the issue.

Couple dynamics became a factor in the parent group. In this experience family dynamics impacted recruitment, group dynamics, member learning as a couple, learning carried to and from other modes of treatment and member retention.

The Ending Stage

The ending stage of a group can be divided into three major areas: 1) the ending

phase of the group sessions; 2) evaluation; and 3) recommendations for the next group.

The following will review the ending phase of the group while the discussion on

evaluation and recommendations will be presented in the evaluation chapter.

The Group Ending Phase

Doel and Sawdon (1999) explained that it is not unusual for a group to have an

extension if warranted only on the condition all members agree. The parenting group

was extended by one week and this was decided upon in the second last session. One

couple had a crisis and missed the fourth session on active listening that was an integral

part of group work. The other couple did not attend for the sixth session on making

agreements that was one of the most crucial sessions of the group. At the start of the

sixth session couple one agreed to catch up on the active listening session, and the other

couple agreed to postpone the group by one session. In a small group the extension was

beneficial for both couples; however, in a larger group this could be inconvenient and

some members would miss important content components of the group.

One important aspect of group endings is dealing with closure by consolidating the

changes members have made and providing rituals that celebrate the end (Doel &

Sawdon, 1999). The sessions were counted down in order to signal the ending of the

group. On the second last session we said goodbye to one of the co-leaders. The director

provided funding for baked goods and coffee for the last session that helped to celebrate

the ending. We reviewed each of the sessions to acknowledge what members had learned

over the course of the group. The members were asked what they remembered the most

about the group. The agenda for the last session had two additional components: to spend fifteen minutes on community resources and on evaluation. As the session continued the conversation naturally focused on evaluation.

Dealing with unfinished business is an important piece of group endings. The last session had three members in the group: Linda, Terrence and Nicole. There were no outstanding issues between members. We acknowledged Linda's partner Mark for his contribution to the group, although he had decided to leave the group earlier.

Part of the evaluation included spending time looking at the material that was covered over the six sessions. We held a discussion with members and placed their comments on a flip chart. Members were invited to share viewpoints that differed. Looking back, the ending of the group had too much of a focus on evaluation and could have presented a stronger ending in terms of a better ritual for group members. The group had a support component. Members commented on what educational material was important to them in the group; however, it would have been helpful to further explore how the information resulted in changes in their lives.

Post group activities involved discussions with the group co-leaders and sharing feedback with the team. Much of the discussion focused on ideas for the next group. This will be elaborated further in upcoming recommendations discussed in the chapter on evaluation. At the time of this writing, the I.C.A.T.S. team had run four parenting groups since its inception that are heavily based on the group implemented in this practicum.

Conclusion

Designing and implementing the parent's psychoeducational group has been a major learning experience in this practicum. Designing and implementing the group gave an opportunity to further enhance knowledge of parent educational material in mental health. In starting and co-facilitating the group, this experience provided a great opportunity to work closely with members from other disciplines in the I.C.A.T.S. team. Group dynamics play a fundamental role in member learning. When members were from the same family, the risks and rewards can be more pronounced. Applying evaluation methods provide important learning for a student, which continues when the student is a practitioner. This contributes to providing improved service for subsequent groups.

CHAPTER SIX – EVALUATION

Introduction

A major component of learning in this educational practicum involved the evaluation of the interventions to guide practice. Evaluation of the family and group interventions included a review of the data collected from the planned use of formal measures and from informal resources. Evaluation of interventions is intended to "monitor changes to provide feedback on success or even failure" (Bloom, Fischer & Orme, 1995, p. 40). This chapter will include two components of evaluation from this practicum: 1) family interventions and 2) the group intervention.

Family Interventions

In the family interventions the CSQ-8 developed by Attkisson, (Corcoran & Fischer, 2000) and the use of solution-focused scales were used for evaluation. The FAM III (Skinner, Steinhauer, & Santa-Barbara, 1983) was administered with some of the families as this measure was available for use in the agency. Client feedback given by clients or solicited by the writer also contributed to this evaluation. In certain families non-obtrusive and non-reactive measures (Bloom, Fischer & Orme, 1995) such as client records provided another dimension to the outcome process. A review the evaluation of each of the six families follows.

Family One – The Maxell Family

The Maxell family attended for a total of four sessions; one session was devoted to the case management functions of medication management and questions on diagnosis. Jennifer (identified patient) was readmitted into the in-patient unit after the third session. Final measures were not administered since the family was under stress and it was

inappropriate to ask them to complete an evaluation; therefore, the final FAM III and the CSQ-8 were not completed. Verbal client feedback came from comments in the session. A scaling question was used with this family and the FAM III was completed at the initial session.

The Scaling Question

Clarifying goals using the solution-focused intervention began during the second session with this family. Solution-focused questions helped to determine that one of Jennifer's main goals was to be trusted more by her parents. The first session baseline was reported with two different numbers. This occurred when Jennifer reported ambiguity about her situation. She said the score was a one out of ten when her room was searched, and she felt it was a three out of ten when her parents reminded her of her past drug use. In using both scores to calculate the final change in scores, an improvement of 40% - 60% was noted in the teenager's perception from the first to third session (see Table 3).

Table 3

Solution-Focused Scaling Results –Family One

Goal: Jennifer wanting to be trusted more by her parents		
Session:	**1**	**3**
Jennifer	1/10 & 3/10	7/10

Jennifer accounted for the improvement by reporting that she saw her parents as being less restrictive when they allowed her to go out on the same day that she asked. The parents committed to helping their daughter and making changes, and this was confirmed when they reported they took time to search for facts before reacting to a circumstance that implied drug use, but was not so.

The scaling intervention had some benefit as Jennifer showed more contentment with her situation due to the effort made by her parents. As goal setting is clarified throughout the intervention (Lipchik, 2002), a further area of development would include what the teenager can do to achieve the parent's trust in this question. This was addressed in an intervention on building and agreements; however, it did not occur through the use of the scaling question.

Client Feedback

The family provided verbal feedback regarding two situations that were helpful. In the first situation, the mother commented that she liked working on the building agreements that occurred in the third session. The two parents worked privately on a list of what they wanted from their daughter in order to give her permission to attend a sleepover. Jennifer was later invited into the session to review the list. In the second situation, involving a case-management intervention, the parents thanked the psychiatrist for clarifying questions on medication and diagnosis. The parents later thanked the writer for inviting the doctor at the end of the family session.

<div align="center">

Family Two-The Sanchez Family

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In evaluating the Sanchez family, information was gathered from the S.F.T. scaling question, the FAM III, CSQ-8 and from miscellaneous sources unique to the client situation. The family attended a total of five sessions (three as a whole unit and one with Alma). Family sessions came to an end when Alma, the mother, went into surgery and her two daughters did not show up for a scheduled session. An opportunity arose later to meet with the family for a medication review and post-counselling measures were completed at this time. Only two of the three members filled out reports since Louisa

could not attend the discharge meeting. One month had elapsed between the last family session and the discharge meeting. A follow-up opportunity arose to collect information during a phone call with Alma after the discharge meeting.

S.F.T. Scaling Question

The scaling question was used four times throughout treatment; the first and second sessions, the discharge meeting, and in a phone conversation one week later when Clarissa was in a crisis. Results of the scaling question with Alma, the mother, and with the identified patient's sister are provided in Table 4.

Table 4

Solution-Focused Scaling Results -Family Two

Goal: Confidence in Clarissa's safety			
Session:	**First Feb/03**	**Second Feb /03**	**Discharge Meeting April/03**	**Follow-up Phone call June/03**
Alma	1/10	N/A	9/10	9/10
Louisa	2/10	2/10	N/A	N/A

These numbers show a remarkable change of eighty percent in Alma's perception from the first meeting to the discharge meeting. Alma reported the change also continued at the time of the follow-up when Clarissa was in a crisis and told her mother "I'm not suicidal. I just want this pain to go away." This statement is similar to the reframing statement used by the writer during the intervention. The goal measured Alma's perception, which was related to the primary complaint of worry about Clarissa's safety.

The FAM III

In family two, the pre-counselling and discharge scores were available from only Alma, the mother, and Clarissa, the identified patient. Louisa, this sister did not fill out the FAM III at the discharge meeting; however, her pre-counselling scores are used in the analysis. Improvement was shown overall for the two family members who completed

the questionnaires. Alma's total average rating changed from a score of 61 to a 54, showing a drop from the problematic range into a more solidified position in the average range. For Clarissa, the identified patient, the overall average changed from a score of 51 to a score of 48. Clarissa's scores were in the average range at the time of crisis, indicating her perception of her family as a source of strength for her. Clarissa's post-counselling scores were also in the average range yet still showed overall improvement from the pre-counselling scores. Areas of improvement included task accomplishment, role performance, involvement and control.

In the area of task accomplishment Alma's scores changed substantially from an elevated 74 to the average range of 58. Louisa's pre-counselling score of 84 shows that Louisa and Alma perceived problems in task accomplishment to be severe, while Clarissa did not share this concern. The lowered score for Alma at discharge shows that she perceived more control over problem solving and crisis achievement. At the time of the first session measurement, the family was facing several challenges: Clarissa had an acute suicide attempt, Louisa had not yet told her mother she had dropped out of university and Alma was facing surgery. By the time of the discharge meeting a lot of the previous tension had subsided. Clarissa had found new alternatives to deal with her suicidal thoughts, Alma was recovering from surgery, and Louisa had sorted out her problems and found a new direction. Alma's remarkable drop in score could be due to overcoming the crisis with Clarissa and the crises in other areas of family life as well.

Scores for role performance showed improvement for both Alma and Clarissa. Clarissa's scores showed a moderate improvement from a 60 to a 56. Alma's scores changed from a 66 to a 52, a move from the family problem range to the average range.

Role performance refers to the family's ability to share roles. Using the FAM III, the issue of one member trying to be the centre of attention in a family is an indicator in the area of role performance and this theme arose in family sessions. Clarissa discussed that her group experience had affected her as she recognized how she had to have a problem in order to get attention in her family. Alma questioned if she may have encouraged this. Alma's score indicated a change where she perceived that one family member no longer tried to be the centre of attention. A discussion with Alma would be needed to clarify reasons for the difference in her score, and one has to be careful not to attribute direct causality for changes. Many other factors, including Clarissa's improved functioning at the time of discharge, could have contributed to the improvement in role performance.

Other areas of improvement for this family were involvement, control, and values and norms. At the time of the first session these scores were in the average range for all three family members. All family members' scores were clustered around each other, indicating agreement and high validity. Clarissa and Alma's scores showed improvements indicating these areas were strengthened for them. In sessions, Alma generally showed a degree of latitude with her daughters in terms of freedoms; however, the improvement of Clarissa's and Alma's scores may be partially accounted for in that Alma was less intrusive at the time of discharge. An example of this would be that Alma was more trusting and could leave out dosages for several days of medications, compared to giving out one dose at a time when the family began sessions.

Although there was a lot of overall improvement from pre-counselling to post-counselling, the area of communication showed an increase in scores indicating a worsening of communication. Alma's and Clarissa's scores show they both perceived

this area to worsen although the scores continued to be in the average range. Communication was not a theme addressed in the family sessions. Another area of question was the affective expression scale. Louisa's scores indicated she perceived this area problematic at during the initial measurement. It would have been interesting to see if a change would have been reflected in Louisa's scores; however, she did not complete the final FAM III.

The scores in the area of denial changed for Alma and Clarissa. Low scores in the area of denial indicate a distortion. Alma scored 28 and Clarissa was at a 40 near the problem area, at the time of the first family session. At discharge, both scores were improved and moved into the normative range of 43 and 46, indicating less distortion. This improvement was quite surprising. The family was in crisis at the time of the intervention. Given that the family only attended for five sessions and the crises had subsided, a question remains as to whether the FAM III pre-counselling scores were distorted and thus the post-counselling scores reflect normative functioning as well.

The C.S.Q.-8

The C.S.Q.-8 was completed at the final discharge meeting. Only Alma and Clarissa completed this scale. For overall ratings Alma gave a score of 18 out of 32, which indicates 56% satisfaction rate. Clarissa had the same score (18 out of 32, or 56%). Both scores show a fair to good satisfaction rating with the service.

Alma explained that she was dissatisfied with previous agencies; therefore, a low satisfaction rate with the I.C.A.T.S. service was expected and even modest satisfaction could indicate a positive rating of the service. The team psychiatrist had warned at the end of the intake session that I was not to be surprised if Clarissa had a fatal suicide

attempt and if Alma was dissatisfied with the service. Alma had complained about other agencies in the initial meeting. The doctor was also concerned as Clarissa had a history of suicide attempts and her last serious attempt was an impulsive act, placing her at high risk. The clinical supervisor also discussed the likelihood of social workers encountering a client fatality in their careers. The psychiatrist's comments were an attempt to prepare the writer in case the worst outcome occurred.

Out of a total rating of four C.S.Q.-8 item, all ratings were in the midrange of a score of a three (indicating good) or a two (indicating fair), and no items were scored on the extreme end of the continuum indicating a four (excellent) or a one (poor) service. In terms of good ratings, the C.S.Q.-8 shows both mother and daughter thought the quality of service was at a good level. Alma felt the services helped somewhat in terms of dealing more effectively with her problems. Clarissa did not express the same sentiment in terms of finding the services helpful in dealing effectively with her problems. This is not surprising as Clarissa received little service and did not follow through with family therapy or additional offers of group and individual treatment. Clarissa's scores indicated ambiguity in that she generally received the *kind* of service she wanted by rating it a three out of four, and yet reported that only a few of her needs were met. One limit of this scale was that it required the clients to rate the overall program service. This did not separate family therapy from group or case management services. Another concern in using this scale with the adolescent population is that written comments provided little detail and feedback was expressed in very general terms.

Miscellaneous Feedback

Other feedback came from client comments and client behaviours that directed case management interventions. Clarissa dropped out of the group because she felt it was too juvenile for her, and did not respond to an additional offer of group therapy. Alma expressed that she wanted more services for her daughter at the discharge meeting. The three-month service was extended and an offer of individual treatment was made in response to client feedback; however, Clarissa declined the offer. This case resembles the research on the barriers to treatment adherence for suicidal youth. Only one-third of suicidal adolescents had shown a completed followed through with family therapy, and only 50% completed individual therapy. The results are generally lower for those who have a distant father and a mother with depressive and paranoid symptoms (King, Hovey, Brand, & Wilson, 1997).

In this case two incidents indicated improvement in the area of client behaviour. First, at the onset of family therapy Alma would only leave Clarissa enough medication to cover the time Alma was away; for example, leaving out morning and noon medication if she was at work, or a dosage at a time. At the discharge meeting Alma commented that she was leaving out four days worth of medication at a time and felt comfortable in doing so. Alma's behaviour of leaving out an increased amount of medication emphasizes progress made in terms of less worry of her daughter's suicidal ideation.

The second area of improvement involved use of services. Six months prior to treatment in the I.C.A.T.S. program, Clarissa made three visits to the emergency department due to suicidal complaints. The first visit was due to an overdose, and as a result the client was admitted to the in-patient ward for one day. The second visit that

occurred one month later resulted in an admission to the community crisis stabilization unit. The third visit was a medication overdose that resulted in a two-week stay at the in-patient ward. There were no visits to the emergency department during the intervention in the outpatient program; however, and there was only one visit to the emergency department at the seven-month follow-up that was non-psychiatric. The improvement in this case raises a question of validity since the medical chart does not indicate use of services through other hospitals. Although Clarissa used services seven-months post-intervention, this does suggest that for a seven-month period psychiatric hospital intervention was not needed.

<div align="center">Summary</div>

Collecting evaluation data from multiple sources was very useful in this case. The more sources used, the better the chances that progress can be traced (Bloom, Fischer & Orme, 1995). If only one measure had been used, i.e. the C.S.Q.-8, this would have been challenging to analyze, as clients cannot always articulate all areas of change. Honest feedback from team members, such as the psychiatrist, was helpful to the writer in keeping a realistic perspective in that not all clients will be satisfied with the service received. For the family and the clinician, the solution-focused scale was beneficial in describing perspectives of family members and in helping family members articulate change. The self-rating scale complemented the standardized measures by being sensitive to subjective experiences.

Most importantly, improvement in the family's main primary area of concern was addressed. Alma's fear of losing Clarissa to suicide had subsided. Exploring pre-session change indicated she was no longer suicidal. Clarissa remarked in family sessions that

she came to the understanding that her family would be devastated if they lost her. This made an impact on Clarissa as she stated she had not previously realized how this affected them. An important area of family concern was addressed over a relatively brief period of intervention.

Family Three – The Van Dorn Family

Evaluation of interventions with the Van Dorn family consisted of the scaling question, the CSQ-8, and other unique characteristics to this case. This family was seen for a total of eight sessions (one session was with the mother Donna, and one session with Deanna, the identified patient only). Deanna did not attend the final session; therefore, she did not fill out the final questionnaires. The FAM III was administered at the pre-counselling stage to all family members; and Angela and Donna completed the forms at the final session.

The Scaling Question

The scaling question was used only once in the course of treatment. While the scaling question does provide some feedback it was more challenging to collect data in this case, since different themes were pursued and often the clients were not ready to move into solution building. This question was used in the fourth session when the mother, Angela, and the daughter, Deanna came to the session with many positives to report. The goal was framed in terms of trust. A retrospective baseline was obtained; Angela felt she had been at level one out of ten in the previous week in terms of trusting her daughter. In the current session Mom rated trust at a level of three, resulting in a twenty percent improvement from the previous week. Angela commented that her daughter's behaviours had improved (telling the truth, home for curfew and respecting

parent decisions). The conversation continued to focus on what Angela would hope to see from her daughter.

While the scaling question was useful in the above session, challenges arose when applying the scale in subsequent sessions. In particular, tension was often high and discussing issues of building trust would have reminded Deanna of more negatives. There was a struggle between selecting individual goals or group goals in the family environment; the need to incorporate everyone's viewpoint on most goals is necessary. One disadvantage of using the scaling question as an intervention and a measuring tool occurs in striking a balance between obtaining necessary information and maintaining the solution focused approach.

The FAM III

The FAM III was administered and scoring difficulties occurred. Two of the three family members circled two answers for one question; for example, on one item that inquires on how close members feel towards each other, one person circled both "strongly agree" and "strongly disagree." In terms of scoring, the numbers could not be averaged out and the resulting score for the involvement category would have been on the cusp of average at a 60 or in the family problem area of 72, depending on which answer is factored in. The double answer reflected the different views Angela had of her two daughters. In the writer's opinion, the relationship between Angela and Donna would have reflected the score of 60, and the relationship between Angela and Deanna (the identified patient) would be rated at a 72.

The problem in this situation was that the general scale of the FAM III was not fitting for this family in which members had different feelings towards each member.

This was reflected in scoring where members had two different ratings for one item. The use of the FAM III dyadic scale would have been more appropriate in this type of situation.

C.S.Q.-8

The mother filled out this questionnaire for the family. The survey was given to the client's sister Donna; however, Angela chose to combine her Donna's comments on one form. Deanna did not show up for the last session and did not fill out a form.

The total score for the C.S.Q.-8 was an average rating of 2.63 out of 4, or 65%. In the comment section the mother wrote: "The program is good and Susan was very good, but in my daughter's case it wasn't helpful being that she needs more help or just a different way of help." This reflects a previous discussion with the mother that family therapy was less suitable for her and she was looking for additional resources. In the solution-focused approach, attention is paid to what works for the client. The mother came to the realization that family therapy was not giving her the change she wanted (i.e. reducing acting-out behaviours). What seemed to be working for the mother was the involvement of probation services and this guided a case-management decision.

As a clinician the C.S.Q.-8 was a useful questionnaire as it gave important feedback on the case. The items that were given a low rating of fair (two out of four) addressed the effectiveness of the service in meeting the family's needs. This is of no surprise, as Deanna's acting out behaviours worsened at the end of treatment. Deanna would make agreements in morning sessions and then skip school on the same day. Because of this, Angela decided not to bring Deanna to the last session and ended family

therapy. These lowered ratings of family interventions supported the case management decision to contact the probation officer and advocate for increased daily supervision.

Despite the struggle with the family intervention, the writer was able to join well with the family. This was indicated by the mother's written comments on the C.S.Q.-8 (see above). Another indicator was that the family attended sessions regularly. Deanna was respectfully informed that family therapy came to an end because her safety was the priority. In the final session Angela reported that Deanna asked if she could attend. The writer would have not had a problem if Deanna attended; however, Angela made this decision and as a counsellor it was necessary to show support for her as a parent. Deanna's willingness to attend displayed a level of comfort with the counsellor.

Miscellaneous Feedback

At the beginning of family sessions, Angela commented that she was tired of making visits to the children's emergency room for what seemed to be of little benefit According to the medical chart Deanna had two visits to the emergency room with suicide complaints three weeks after her inpatient admission and two weeks before beginning treatment in the I.C.A.T.S. program. The next psychiatric visit to the emergency room occurred six weeks after the end of treatment. This information indicates that while in treatment in the I.C.A.T.S. program, the client made fewer visits to the emergency room for psychiatric reasons, possibly indicating that attending the outpatient services provided the client with a form of support.

Summary

The evaluation is limited as not all measures were obtained for feedback. The FAM III general scale is not fitting in cases where members have strongly different viewpoints towards other members. Another reality in a practice setting is that not all clients show up for all sessions. In this case, open-ended questions on the C.S.Q.-8 gave subjective feedback that could not have been obtained by the FAM III. The scaling question was difficult to administer while trying to remain consistent to the solution-focused approach. Although the solution-focused family approach was limited in this case, one benefit may have occurred in that fewer emergency room services were used while the client was attending the I.C.A.T.S. unit.

Family 4 -The Taylor Family

The Taylor family was involved in family therapy, group therapy, case management and individual treatment. Eight sessions of family therapy were held; two sessions with three family members, four sessions with the parents only, and two sessions with the mother only. This evaluation does not include the individual treatment Jordan received. The parents did not attend the final session, nor did the daughter attend her final session in individual treatment. Evaluation tools were mailed out along with a letter; however, they were not returned. Feedback was thus obtained from the scaling question and verbal feedback given by the parents.

The Scaling Question

This question was used in the third session with only the parents in attendance. The scaling question was of little benefit for the family. It explored couple communication. Theo informed me that he could not understand how the scaling intervals

could be accurate and he disagreed with how his wife was rating his behaviour. One of Theo's strengths was that he had a genius-like brilliance when it came to precision and detail, and the writer observed he had difficulty accepting general statements made by others. Theo's feedback was important to informing practice. Although the intervals between client anchors are subjective, it became apparent that this technique was not a good fit for him and there was a need to "do something different" (de Shazer & Molnar, 1987) in order reach the client. An important factor was the timing of this technique as the couple was discussing problematic situations. In retrospect more time needed to be spent listening to client complaints.

Client Feedback

Verbal feedback was obtained from clients in family sessions, group sessions, and phone conversations. In terms of case management, Janice often remarked that the many connections to services were very helpful. Most referrals came from other helpers in the system. On one occasion the parents indicated a phone conversation that was much appreciated. This conversation focused on how the mobile unit could assist when their daughter threatened to run away and would not agree to a curfew.

In terms of the group, Janice commented how the agreement technique was working for her. At one point Jordan stayed out past curfew and turned off her cell phone so her parents could not contact her. In a conversation at the end of treatment Janice commented that more agreements were being made. On one occasion, Jordan phoned, told her mother she knew she was late, and immediately began to negotiate. Janice found the agreement technique helpful; however, additional contributing factors may have involved previous work by the parents such as following up on consequences.

Although the family evaluation tools were not returned, verbal feedback on the family intervention was both positive and negative. At the end of the first session the daughter commented that she found it useful to attend as her father made an apology to her and she felt better about attending therapy. The daughter subsequently dropped out of family therapy, and the mother explained that family counselling was too much for her as she was also attending individual therapy.

As mentioned above the father did not find the scaling question helpful. In a later session, when the writer postponed the use of building solutions and focussed on the couple's negative emotions, the couple said the session was helpful. From the writer's clinical perspective, this approach made a difference compared to other sessions.

It appeared that case management and the group intervention were more helpful than family therapy. The family's situation may have affected the usefulness of family work, as there were many stressors upon the family (unemployment, medical appointments from the accident, financial pressures). All services provided, including group, family, individual, case-management in and outside of the agency, had a cumulative effect in assisting the family. The daughter commented that at first she was against the new approaches her parents were using as a result of family and group sessions. Later on the daughter commented that she appreciated how her parents set more limits. In terms of the primary complaint, at the end of treatment Jordan was going to finish the school year and her self-harm incidents had disappeared.

Family Five - The Jones Family

Marie and Melissa Jones attended for a total of eight sessions, one of which Marie attended on her own. Evaluation for the Jones family consisted of the S.F.T. scales, and verbal feedback. As termination with this family was unplanned, the final FAM III and the CSQ-8 were not completed nor returned, although these tools were mailed out.

The Scaling Question

The scaling question was used at two points in the counselling process: at the initial and final sessions. The question addressed how mother and daughter got along. In the outcome results (see Table 5), both mother and daughter perceived an improvement in terms of getting along. Marie reported an improvement of 50% and Melissa reported an improvement of 40%.

Table 5

Solution-Focused Scaling Results -Family Five

Goal: Improving the Mother-Daughter relationship (in terms of getting along)		
Session:	**First** **Session March/03**	**Last** **Session June/03**
Marie	2/10	7/10
Melissa	2/10	6/10

The scaling technique was very useful in providing measurement of change in perceptions. This was useful for the family in order to show them the progress they had made. Probing into specifics about what actions were making a difference was another source of positive feedback for the clients near the end of treatment. The ease of use was another benefit as there was no long form for clients to fill out. The question was relevant and unique to the client situation and informed of change that may not have been addressed in measures.

As a clinician the scaling question had many benefits for the writer as well. As the family counselling ended unexpectedly and mail-out tools were not returned, the scaling question provided valuable feedback about the family's progress that may have not otherwise been obtained. The scaling question was also useful in probing for additional comments that sometimes are not reported in independent measures.

Some limits existed with asking the scaling question in a family situation. Family members could change their opinion to avoid a conflict; for example, if one member did not want to hurt another's feelings. Another challenge was to gather enough ratings to gain a sense of the direction of change. At times it seemed inappropriate to inquire into the goal when a lot of tension and sarcasm existed in the room.

The scaling question was very fitting in this case as one of Marie's strengths was that she was goal focused and could make decisions quickly. The face validity of the scaling question worked for clients, as they maintained their focus on the goal of improving their relationship.

Client Feedback

Comments from clients are useful in receiving evaluating the intervention. During the counselling process the mother explained that she found therapy helpful as she enjoyed the time to spend with her daughter and getting to know her better. The mother commented on two occasions when the writer probed further into her daughter's comments and drew out more information that the mother may not have paid attention to. The mother also commented that she felt the counselling process gave her more confidence as a parent.

At one point in treatment the daughter informed the writer that she did not think therapy was working as there were many arguments with her mother. This comment was made at the end of a session, just after the role-play exercise. The writer also noticed a struggle to move forward due to interference from communication problems, which raised a question about the impact of the role-play. In the following session, I noticed the dialogue was more productive as there was less sarcasm and verbal attacks. Melissa's comments were helpful indicating a need for change in the counselling direction. The role-play seemed effective despite the initial resistance from the daughter.

Another source of feedback came from the mother's inquiry if the writer was available for future sessions, as she wanted to bring in the rest of the family to address other issues. This comment is similar to a question on the CSQ-8 that probes if clients would come in for future service. This indicated that the family found the service useful since they wanted to return for more sessions. As the three month client contract was coming to an end the family was referred to a community service.

Summary

Other factors in treatment success that occurred outside of family therapy included the impact of medications and client participation in individual counselling with another therapist. It is unfortunate that the post-counselling evaluation measures were not completed, as it would have been helpful to see if changes occurred in the area of communication on the FAM III. The use of the scaling question as a self-rating scale provided much needed evaluative feedback. This underlines the importance of using a variety of measures in the event that clients are not available to complete standardized measures.

Family 6 - The Waters Family

The Waters family was referred from the children's emergency department. There were nine sessions in total. Madeline and her parents attended the first session together, Tracey and Darren attended one together, Madeline attended three on her own, Madeline and her mother attended two sessions as a unit and Darren attended two on his own. Evaluation for interventions with the Waters family consisted of the S.F.T. scales and comments from clients' verbal feedback. The family did not attend for a final session and final measures were not completed.

The Scaling Question

The scaling question was asked two times in treatment. As attendance changed often with different members attending at different times, along with different themes addressed in sessions, these questions were not addressed further. In a subsequent session alone with Darren and Tracey Waters, they discussed how to elicit more co-operation from their teenagers in terms of helping out with chores. Later in treatment, Darren could not attend and Tracey wanted to address a salient issue that arose around cutting and self-harm. Thus, scaling was helpful in terms of understanding their baseline, yet goals and themes changed (Lipchik, 2002). In the short-term treatment, it can be difficult and unrealistic to revisit earlier goals and when more important issues arise. One way to address this in the future would be to take only a rating and acknowledge to the client that certain goals are on hold while more important issues are addressed.

Client Feedback

Comments from clients are useful in terms of feedback to a clinician when more formal measures are not available. One theme of progress centred on the issue of self-

harm. At the initial session, Madeline denied self-harm behaviours of cutting her wrists with a knife. Her mother said she was still worried about it since she found towels with bloodstains on them. This theme did not re-emerge until the middle stage of treatment where it was addressed in several sessions, after a self-harm incident. Madeline was then willing to discuss the issue and a coping plan was made. Later, Madeline and her mother reported that Madeline used her coping plan successfully when she was tempted to cut. In a follow-up session Madeline said that "cutting [self-harm] was stupid" and she felt the issue was over for her. In a follow-up phone call with her mother she commented that counselling helped in addressing the self-harm issue, which was one of the main concerns in treatment.

Summary

Findings are limited to client comments in this family. Goals changed over the course of treatment and the solution-focused scale could not have been applied to every goal that arose. Unfortunately, as termination was unplanned, the final measures were not filled out. Client comments and regular attendance of sessions became the basis of evaluation. Progress was reported in the main area of importance to the family that was presented at the onset of treatment, the daughter's self-abusive behaviour.

The Family Assessment Measure III

The FAM III was administered at the pre-counselling stage for all of the families. Only one of the families had post-counselling results available at the end of treatment. Despite this low number, the measure provided tremendous learning for the writer in terms of using the tool in assessment, interpreting results, directing the intervention process, and providing feedback to team members and families.

As a rule, results of the pre-counselling scores of the FAM III were not presented to most families. All of the families had very elevated scores in the assessment indicating many problem areas. In many cases this decision seemed appropriate since the FAM III was not theoretically consistent with the solution-focused intervention. Presenting the results of the assessment measure would reinforce a problem perspective and could overwhelm some of the families. There was one exception where the FAM III results were presented to the Jones family, as the mother was open to the feedback. In preparation for this, the writer reviewed the results with the psychiatric nurse therapist beforehand to ensure that the presentation of the constructs would be clear for the family.

Certain concerns of the family arose with presenting the FAM III results. Elevated scores in some areas distressed the daughter. Great care was taken to emphasize the difference between viewing these areas as problematic in the family versus blaming the person for the problem. In this case she was reassured that her scores indicated that she viewed areas as problematic and it was important to know what her concerns were. The other area of concern was that the constructs seemed confusing to family members, as there is overlap in some areas.

The FAM III was quite useful in guiding clinical assessment and intervention. The measurement tool is not to be used as an assessment replacement (Skinner, Steinhauer & Santa-Barbara, 1983) but is useful to support assessment observations. In family one (see Appendix E), team members observed how the mother was overly concerned over her daughter's problems, indicating a possible imbalance and not looking closely at her own life. The daughter's extremely high score of 84 in the involvement sub-scale reflected the daughter's discomfort with this.

Analyzing and interpreting the FAM III results is more complicated compared to the other measures used. Each of the families had a unique aspect in interpretation. In family one, the father had an elevated score for denial and social defensiveness indicating a need to present the family in a favourable manner. This could be matched with the assessment where this individual was more sensitive/defensive when members described family problems. In this family, the teenager in family had an elevated rating for values and norms. This suggests a struggle between the family's culture and the North American culture. The father commented about the rude comments of teenagers that are rare from his former culture. This was addressed with the family, normalizing the parents' struggle in maintaining their values in a North American culture. In family four (see Appendix I), the direction of the graphed scores is similar for each family member and the scores are clustered in many areas. When family members scores are clustered, higher score validity was suggested (Skinner, Steinhauer & Santa-Barbara, 1983).

Validity of the scores came into question even when the ratings for social desirability and defensiveness met the requirements of a score below 40. In two instances, family two (Appendix G) and family four (Appendix H), a family member's

score would be in the average (non-problematic) range while other family members had elevated scores. Both individuals with average ratings were experiencing great difficulty in functioning with being productive in their lives. This appeared unusual as both of these families were in high crisis and were experiencing a lot of tension. This was in contrast to the situation in family six (see Appendix K) where scores were elevated yet the client was functioning very well in school and was keeping up with extra curricular activities. The FAM III is a measure of family functioning and not productivity. For the individual who is functioning well in school and had elevated scores, the FAM III validates that family tension is a source of stress for this individual.

Validity came into question when scores for social defensiveness and denial are below 40 and in the range that describes areas of family strengths. The interpretation guide is vague in its explanation; however, one might presume that a score of under 40 might indicate a lack of denial, which is unhealthy. The interpretation guide described the "distortion" of the scores as a possible indication that some other problem is occurring to which the measure is not sensitive (Skinner, Steinhauer & Santa-Barbara, 1983). In family two, the scores under 40 for denial may have referred to the crises the family was experiencing and thus, the scores may have been as extreme in the initial assessment.

For the clinician, the measurement tool was useful for supporting intervention decisions. In family five (see Appendix J) the high scores in the communication area were consistent with observations of how the mother and daughter's sarcasm and defensiveness got in the way of solution building. The results of the FAM III supported the need to hold a session on role-playing communication skills. This decision was a

crucial one in terms of guiding the direction of counselling, as moving into solution building became much easier after this point.

Administering the FAM III had challenges. In family counselling, not all members were present at the first or last sessions. As a result, some completed the pre-counselling measure after the intervention had begun, and in other cases the post-counselling scores missed one member's viewpoint. Another problem occurred when the Van Dorn family found the scale was not fitting for them. Family members circled two answers for one question. An example of this was that the mother answered that she strongly disagreed with one daughter and strongly agreed with another. This made scoring of the post-counselling results impossible, as it would be difficult to sort out two different ratings. In this case the dyad scale would have been more appropriate to use in this situation.

Another problem with administering the final evaluation occurred when terminations were not planned, as was the case with most of the families. The questionnaires were mailed out and the poor response rate was consistent with mail out surveys. In one family, the client was readmitted to the in-patient ward. The parents were quite distressed over her health and asking them to fill out final scales would have been inappropriate. In the group evaluation, more emphasis was placed on signalling the end of sessions and the importance of client feedback. The writer learned that in the future this same approach would be useful with families as well.

In comparison of pre-counselling to post-counselling scores for family two (see appendices G & H), the results showed quite a level of improvement for only five sessions. Scores in the areas of social desirability and denial improved into the average

range, indicating less distortion. This supports how the FAM III was sensitive to the crisis level of pre-counselling scores. Evaluation using post-counselling scores was useful; however, there are additional influences in the interpretations. In the short-term treatment unit medication, case-management, individual and group therapy are part of the client's treatment intervention. It is also not unusual for family members to receive additional treatment services from outside agencies. The suitability of the FAM III with families who are in crisis came into question as pre-counselling scores suggested ratings in highly elevated areas.

In this practicum, the use of the FAM III provided many learning opportunities. As a clinician, this was useful to strengthen assessment perspective and guide the intervention process. This measure was useful for certain families; however, presenting the results from the measure was difficult when families were in crisis. As families may be overwhelmed with having a teenager in the mental health system, a report of family liabilities could be contraindicated at the time.

<center>Group Evaluation</center>

The group evaluation was done in two parts: a written and verbal evaluation. The written evaluation consisted of a modified version (see Appendix M) of the C.S.Q.-8 developed by Attkisson in 1985 (Cocoran & Fisher, 2000). Three group members competed the questionnaire. The questionnaire contained 13 questions consisting of Likert type rating scales and open-ended questions on themes related to quality of service and group content. Each Likert question had four anchors with an assigned point value ranging from poor (1), fair (2), good (3), to excellent (4).

Results from the client satisfaction questionnaire were positive. The total score was 171 out of 192 possible points for an overall average of 89%. Areas of satisfaction that received ratings between 75-83% (3 or better) were that material was presented in an interesting and informative way, group facilitation, and dealing more effectively with their teenager. Topics that were rated in this category were healthy and unhealthy family characteristics (75%), mental health and illness (83%), adolescent development (83%) and stages of change (83%).

Highest ratings (91 % to 100%) were reported for the overall quality of service, overall group satisfaction, meeting the needs of members, and recommending the group to other parents. In terms of group content, the topics that received the highest ratings from members were tools for communication (100%), control battles with teenagers (91%), making agreements (91%), and community resources (100%).

In addition to the written evaluation members provided verbal feedback in a discussion during the final session. Overall, the verbal comments were more detailed than the written feedback. The discussion period was helpful since co-leaders were able to probe for more detail. The members commented about the content of the material presented and group process, identified what was helpful and what needed to improve.

In terms of group content most information was found to be important. Members rated each overall session theme good or excellent on the written evaluation. Some parents verbally agreed that the group gave a better understanding of mental illness apart from normal adolescence. One parent commented that she has "more acceptance for who she [her daughter] is." One couple commented throughout the group and in the evaluation that Miccuci's (1998) chart that separated mild, moderate and severe acting out

behaviours helped them to keep perspective when a mild problem felt severe in the moment.

One topic covered the arguments for and against searching a teenager's room. A parent remarked that she found it helpful to know that the inpatient ward would search through a teenager's belongings with the teenager present. Parents remarked that the five- minute presentation of studies on adolescent brain development was worthwhile. One mother commented that she worried her child was a "bad person" and now could show more understanding. Prochaska and diClemente's (1984) "stages of change" theory was found useful by one parent. This theory helped the parent accept that change occurs over the long term. This parent commented that she would like to see more coverage on dealing with a teenager's denial, yet she found that as her teenager was growing she was learning as a parent to better help her teenager. Topics that were not covered in the presented material but arose from the discussion were helpful to parents. In one example, one parent commented that discussing peer pressure was helpful. In another instance one mother commented, "You made me think...(pause) of how having the last word is a control battle. I do that..."

Parents also gave examples of how their learning was carried into their day-to-day lives. All parents remarked that the active listening component was useful, especially the "I statements." One parent found it helpful when their teenager was swearing at him. Another couple commented that instead of trying to make their daughter be more polite, they now validated her feelings more. Another parent commented that he was able to avoid an early morning conflict with his daughter and make an agreement. He did not want her at home and unsupervised for lunch with her many friends, which was an on-

going issue. He agreed to supplement her allowance by one dollar in order for her to have lunch at school.

Group process was another area of discussion. The group members said thank-you for allowing the discussion time to be extended. Parents emphasized that they learned a lot from each other, and it was helpful to brainstorm together. Prior to the group, one parent commented she had become isolated as a parent and doubted herself when her teen told her she was a "bad parent." She added that the group helped her to gain confidence as a parent. Another member commented that it was helpful to have her spouse present in the group since they were able to learn as a couple.

The members also commented on what needed to improve in the group. One member commented that the presentation of community resources should be at the beginning of the group, as this would be helpful when going through a crisis. Members agreed that the section on agreements should be presented earlier on in the group. Members found the discussion of healthy and unhealthy families "too theoretical" and wanted more details of how parents of teenagers are affected. One mother commented that she wanted to hear more on the worst-case scenario of what could go wrong with their teenager's behaviours. Another parent suggested that the issue of blaming family members for the illness be covered more.

In terms of group process one parent indicated more interactive learning was needed and suggested "a role-play for every session." Another member added that role-plays were needed for dealing with extreme behaviours, i.e. the teen threatens to run from home, or is lying. The members commented on the timing of the group. One parent suggested the group be held in a two-day session. Another suggested the group be held

in weekly sessions in order to try out techniques at home. The parents recommended an evening session. Also, one parent suggested the parents' group be offered earlier in the course of treatment.

Suggestions For Future Groups

This group indicated the benefits of group treatment for parents. The parents' group had benefits for members: it can be a powerful mode of change since members learn from each other. Couples can learn together and the group can be cost-effective in terms of providing treatment for more people in a shorter period of time. The evaluation process has provided valuable feedback to carry onto future groups.

One major shift in design of the group would continue in the type of group. The initial concept was to hold a one-hour group primarily with informational material. This changed immediately in the first session at the request of the parents who wanted more time for discussion. In the future the writer would continue to keep the group sessions of two hours, with an additional focus on peer support components. A group provides powerful areas of learning when members learn from each other. The writer would reduce the amount of material presented, increase more interactive learning methods such as role-plays and continue to tap into learning outside of the group by adding homework assignments.

One future consideration is to have the parent group coincide with adolescent groups. Occupational therapists hold regular groups for teenagers that focus on skill development. Having parents learn material that coincides with the teen group could provide a stronger intervention in the family environment. One limit of a coinciding adolescent group exists in terms of recruitment. Previous parenting groups in the long-

term child and adolescent units were thwarted in terms of member recruitment and commitment with an adjunctive intervention (Kym Cuthill, personal communication, Spring, 2003). Benefits of opening recruitment to parents who had youth in short-term and long-term outpatient services include the larger pool of potential members, and parents had access to the group intervention when their adolescent had declined the offer or withdrawn from group treatment.

Session content and agenda layout was continually revised before and during the group, and should continue to be revised in future groups. The themes should remain the same. One major area of change would be in the session of healthy and unhealthy family characteristics. This theme has importance as it provides the theoretical foundation of the skills that are presented in subsequent sessions. How the message was delivered would change; for example, instead of providing material on different types of families on a dual continuum of stability and flexibility, the parents could explore learning through their family of origin by explaining how their parents dealt with limits and freedoms. One parent had suggested a need for less generalized material and more information that dealt with extreme behaviours. In taking this comment into consideration, one area of improvement would include more material that is contextualized. This could include how family characteristics, including limits and freedoms, impact adolescent mental health (Fristad, Goldberg-Arnold, & Gavazzi, 2003).

Members' feedback on content change was important. The topic of agreements should be introduced earlier. Other suggestions reflected members' lives and cannot be planned into other groups. In this example, the issue of blame was introduced at the first session and a member felt this should be emphasized in the group. This comment

reflected the timing for this parent in her experience. As a leader, not all issues can be planned for; however, some topics can be addressed in an unstructured group discussion.

A final area of change would occur in terms of evaluation. If the situation arose where another group was to be developed, an evaluation form for every session is needed. Also, the addition of a standardized measure would be helpful to capture if changes had been significant for the parents. It may be helpful to hold a follow-up evaluation session after a few weeks have passed to allow for a more consolidated account in areas of change.

Group Summary

Group evaluation provided important client feedback that guides practice and development of future groups. Giving strong signals to clients to forecast the ending of the group, stressing the importance of their feedback, and providing morning coffee and pastries made the environment conducive for obtaining feedback. Despite the fact that the C.S.Q.-8 had been modified to seek more specific details, clients provided more detailed and useful verbal responses compared to written responses. Future evaluation could incorporate other standardized measures to further enhance the evaluation process.

Conclusion

Evaluation of the clinical work in the practicum provided valuable feedback in terms of what worked in interventions and what needed be improved. An initial expectation of using the solution-focused scale consistently may have been unrealistic as establishing goals with families was a developmental process. Using multiple measures in family evaluation had benefits for the clinician, as more feedback was obtained and some measures are more fitting for individual cases than others. The use of the C.S.Q.-8

in two different modalities provided a contrast in administering the measures. The termination phase of the family process was not as predictable as the group process, which impacted the amount of feedback given. Some families terminated contact prematurely and failed to mail back completed questionnaires; one family transferred to in-patient treatment, and it seemed inappropriate to ask them to complete questionnaires at this difficult point in their lives. Thus, depending exclusively on standardized instruments is a limitation in evaluation, and this increases the importance of direct verbal feedback from families and more indirect sources of feedback such as chart information. Acquiring feedback is essential to guiding social work practice.

CHAPTER 7-CONCLUSIONS OF STUDENT LEARNING

This concluding chapter provides discussion on the achievement of the student's learning objectives for the practicum. Learning occurred in the areas of building skills in solution-focused interventions, family assessments, group planning and interventions, clinical feedback, and the implications for social work in a multi-disciplinary setting.

Objective One

Increase knowledge and experience with solution-focused interventions.

In this practicum the writer had the experience of working with six different families and held a total of forty-three sessions. This allowed the writer to develop a working knowledge of the use of solution-focused interventions with the adolescent mental health population.

The solution-focused therapy model was suitable to this population in several ways. In working with families in mental health this model has been useful in developing client co-operation with teenagers who are similar to involuntary clients, and in building strengths with parents who feel overwhelmed. The model's strength-based principle promotes client empowerment by respecting a client's right to self-determination. The solution-focused techniques of exploring pre-session change, exceptions, scaling, and doing something different were helpful in building upon the efforts clients had initiated. The client-centred focus was congruent not only with social work values of client self-agency, but was a very fitting and appropriate intervention that upholds client empowerment to counter potential loss of basic rights due to illness.

Applying the solution-focused therapy model with this population had its challenges and limits at times when goal setting was not straightforward or it was

difficult to move into solutions. The techniques do not fit well when people need to vent or express complaints. Trying to focus on the positive and force solutions in these situations can be invalidating for clients (Nichols & Schwartz, 2001). The struggle with moving into solution building was partly due to the writer's learning curve in developing family intervention abilities; however, this also speaks to difficulty encountered in helping clients move into solutions (Efron & Veenendaal, 1993; Lipchik, 2002; Selekman, 1993a). The model became easier to apply when the therapeutic focus switched from taking the lead and finding a space to move into solutions, to watching for the client's readiness to move into solutions. By slowing the pace down (Lipchik, 2002), more time was spent validating and addressing emotions, which led to a more natural flow in applying the techniques.

Literature addressing the limitations of using the S.F.T. approach has emerged (Efron & Veenendaal, 1993; Klar & Berg, 1997; Lipchik, 2002; Selekman,1993a). The literature review was conducted in fall of 2002 in preparation for the working phase of this project, and the work of Eve Lipchick (2002) did not become available until after the work with families had ended. The newer versions of solution-focused therapy address deficiencies in the original, more traditional models of solution-focused therapy. The differences between the traditional and revised models of solution-focused therapy are outlined into four major themes in Table 6.

Table 6

Different Approaches to Solution-Focused Therapy

Traditional Approaches	More Recent Approaches
1.Dealing with the Past:	
▪ Marginally addressed ▪ Respected, yet not directly addressed -or- ▪ Excavate for solutions	▪ Relevant and necessary ▪ Address emotions
2. Emotions	
▪ Secondary focus ▪ Assess for solutions: "what's improved" vs. "how are you feeling"	▪ Primary focus ▪ Deal with grief and loss before solution building ▪ Provide more detailed solutions
3. Goal Setting	
▪ 1st session ▪ Brief Therapy	▪ Deal with emotions first ▪ Occurs throughout & up until final session ▪ "S.F.T. goes slowly"
4. Family Techniques	
▪ Little focus on unique needs of applying S.F.T. in a family environment ▪ A client team approach vs. a family unit	▪ Acknowledges skill to move whole family into collaboration ▪ Techniques focusing on family interactions

In dealing with the past, searching for solutions or taking a marginal stance in addressing past issues has been limited. The quick move into the search for solutions can undermine the grieving process by ignoring the emotions and issues surrounding grief and loss (Lipchik, 2002). Addressing emotions (Lipchik, 2002) would have made it easier to facilitate a difficult discussion.

The brief model of therapy, and use of one session only does not fit in all circumstances and was an unrealistic expectation. In family two, the San Chez family,

this was possible as they became very clear about their goal. Getting to know some families and searching for their goal can take a few sessions. For other families, the process of clarifying goals up until the last session (Lipchik, 2002) was very fitting, as this gave opportunities to address several issues that came up in the course of treatment.

Addressing emotions first made a difference in family sessions. In one session with family four, the Taylor family, fifty minutes were spent listening to emotions and complaints, acknowledging the couple's different perspectives and trying to keep the topic from getting off track. It was at this point that a space became available and the search for solutions naturally flowed. Acknowledging emotions, and using the techniques in a slow (Lipchik, 2002) and sparing manner made the model more manageable.

One major question that arose in this practicum was how to utilize the techniques in a family setting. In a family environment, where family members have a higher emotional investment the challenge was to bring the complainants into a collaborative discussion (Klar & Berg, 1999). Respecting the perspective of each family member and not leaving someone "out" can make a difference in solution building, as members move from a skeptical position to an alliance position.

The newer approaches are not better than the traditional ones; however, the more recent approaches provide a foundation for the more traditional interventions in preparing the client to move into solutions. By learning the limits of the solution-focused model and how these barriers are addressed has provided the writer with an enriched view of solution-focused practice. Areas of continued work would involve giving more time to listen to complaints, addressing emotions, slowly moving into solutions, paying attention

to how pertinent past issues impact goal setting, and integrating other approaches such as grief and loss theory when exploring the past.

<div align="center">Objective Two</div>

<div align="center">*Develop assessment and intervention skills with adolescent families*</div>

<div align="center">*in a mental health setting.*</div>

Opportunities to build skills in assessment occurred through attending intake meetings with the multi-disciplinary team at intake sessions. This was further supplemented through the student's family sessions with clients using the solution-focused model and the FAM III measurement tool.

Intake team meetings were necessary to offer the different types of services needed by adolescents and their families; this could consist of individual, family, teen or parent education groups. In a three-month contract, short-term work was fitting as clients can achieve substantial work in the short-term. This also allows for the opportunity for adolescents to try another group, or even another modality if the initial intervention was not fitting.

After a family agreed to participate in family therapy, social work assessments consisting of the solution-focused approach and the FAM III were completed. Both of these approaches have merit, and their differences provided a more rounded assessment. The solution-focused model was useful in determining goals for the short-term and it provided an assessment of family strengths. The FAM III was useful for confirming observed problem areas as well as strengths. The FAM III was also useful for validating clinical direction. The FAM III was of limited use in terms of reporting the profiles back to the families, as negative scores on the profile at times indicated distortion. As a result

this test was a less fitting measure for families in crisis. In terms of developing intervention skills this broad based practicum promoted development in solution-focused counselling and case-management interventions. For the student, the writing and reflection involved in producing this practicum report has enhanced a deeper understanding of applying theory practice. The value of working with different approaches has shown that one was not necessarily better than the other; however, each fit clients' needs at different times. In some cases, case management provided client access to much needed services, while solution-focused family therapy helped work towards goals. Providing the right fit of service to best meet client's needs was essential to the practice of social work. Both interventions are important to the role of a social worker as they target the environment of adolescents in helping them improve their mental health functioning.

Objective Three

Gain experience in developing and co-facilitating a psychoeducational group for parents whose adolescents are dealing with mental health concerns.

Developing and co-facilitating the parenting group turned out to be a very creative and positive experience. The group was started from a blank slate and as the practicum was negotiated, roles were formed. The writer took the lead role by researching and designing the group while sharing co-facilitation with team members. This experience has provided a learning opportunity about group planning, group dynamics and the value of parent psycho-education. Meetings with members of the team, the supervisor Brad, and the co-facilitators, Marlies and Lisa, were used to collaborate and ensure the agenda was meeting the needs of the population based on their experiences. Before each session,

a meeting was held with the co-facilitator to rehearse the session so we were better prepared.

Group Planning

The group had obstacles in its launching and some valuable lessons were gained. Due to the restriction of holding the group within a 9 a.m. to 5 p.m. framework, the expectations of a larger group size had to be modified; thus, the value of a small group was learned. In this instance this group had more participant interaction and this contributed to further learning about group dynamics. The parents had a lot to say about parenting and found the discussion time a valuable part of learning. One major benefit of the group was the normalization that came from interactions with other members.

The planning checklist was helpful as a guideline (Will, 1999). Being open to change was very necessary when implementing the group and for group development. The parents had many questions about dealing with drug use. The opportunity to seek out facilitators from other parenting groups in outside agencies was beneficial for providing meaningful resources for the group.

Respect for the place of psycho-education in a mental health setting has been gained. Compared to family therapy, one main advantage of the parent psychoeducational group was that parents gained support and learned from other parents. In mental health this was important, as parents can feel more isolated in the community and the group normalizes their struggle. Information was provided to reduce confusion about adolescent mental health by clarifying the difference between normal adolescent development and mental illness. Parents have the opportunity to become more familiar with the mental health field and resources available to them and feel more comfortable in accessing these

resources. In the outpatient program, psycho-education provides another tool for intervention that complements the interventions available to families.

Objective Four

*Learn about how to make use of clinical supervision
and client feedback to inform practice.*

There was both on-site and off-site clinical supervision for this practicum. Regular meetings were held once a week with the on-site supervisor, Brad Brown M.S.W. In these meetings we reviewed progress on the group and family interventions; session videotapes and chart summaries were reviewed. Off-site supervision meetings were held with Dr. Brenda Bacon on a monthly basis to review the use of solution-focused interventions with families.

The use of videotapes in family sessions provided tremendous feedback when the writer reviewed them on her own or with Brad or Brenda. Clients were always informed when the sessions were being taped. Approximately every third session was videotaped with the families who gave permission. Infrequent taping was beneficial as this reduced the incidence of sessions being influenced as clients were "on camera." The tapes provided a much clearer recollection of the sessions than could otherwise be obtained. In reviewing the tapes, more positives in the writer's work were identified, i.e. additional times when the solution-focused model was successfully used. Feedback from the supervisor was useful in providing other options in dealing with places the writer had felt stuck. As a clinician the need to continue to consult with other practitioners to further develop clinical skills is important. The use of a reflection team would provide a good medium for this.

Another primary source of feedback came from the clients. There are many different ways of collecting information for evaluation, such as informal probing to see if clients found the session helpful. Verbal feedback was a valuable source of information that guided intervention. In one particular case the mother felt she needed more help than family therapy could provide at the time. This reinforced the decision to pursue a case management intervention to advocate for more intensive services through the probation office. The formal measure, the FAM III, was valuable in that it is a standardized instrument. Becoming more acquainted with this measure was beneficial in expanding the student's knowledge base in assessment skills with families. As the solution-focused model was limited in obtaining family assessment information, the FAM III provided a more comprehensive assessment by emphasizing additional areas and details of family functioning. The FAM III did tend to distort several of the clients' profiles. This led the writer to question if this measure was suitable to this population as many families were in crisis. Another limit of these formal measures was that they could not track all progress, especially subjective areas of progress that are important to clients.

The scaling question provided important feedback as a self-report measure that the more formal measures were not sensitive to. One advantage of these scales was that they are relevant and can be modified to the uniqueness of the client situation. Another advantage was that they have high face validity. The reactivity of the measure was useful as it complemented the solution-focused therapeutic direction in terms of having clients focus on their goals and on positive change.

The CSQ-8 was another measure used to obtain client feedback. It was easy to administer and straightforward for the clients. Modifying the questionnaire to find how

clients felt about each group session was very useful. This feedback will greatly influence future sessions. As clients identified the need to diversify and to use different mediums (i.e., videos or more role-plays). Important feedback was gained on the topics that need to be changed for future sessions; for example, the session on family functioning will need to have less theory and include a role-play. One limit of the C.S.Q.-8 was that clients tended to answer the open-ended questions in a short and minimal style.

Verbal feedback from clients on family sessions was not as extensive as the group feedback. This was mostly due to the formal verbal evaluation with group clients during the final session of the group. The discussion provided much more detailed information on what they wanted to see changed. When starting the next group this type of feedback would be very useful. One influencing factor in obtaining more feedback was that a more active role was taken with the group by emphasizing how important client feedback was and a lot of signals about the ending of the group were given. In order to gain more feedback with individual families in the future, there is a need to stress its importance on an on-going basis while planning for termination.

Objective Five

Learn the role of a social worker in a multidisciplinary team in a mental health setting.

The setting in which this practicum took place was very suitable and congruent with social work. One basic function of social work is to address the relationship between the client and the client's system (Kirst- Ashman & Hull, 1999). Similarly, the I.C.A.T.S. adolescent outpatient services provide services to adolescents with mental health issues that are geared towards helping them reintegrate into their community.

The role of a social worker within the multi- disciplinary team in this hospital outpatient program differs from that of other workers in the team since it was the function of the social worker to provide family counselling. A social worker's role in an outside agency requires the worker to provide treatment in different modalities; however, in the hospital programs these roles are segmented according to profession. Roles are segmented in that only occupational therapists provide groups for adolescents and only registered nurses or registered psychiatric nurses provide individual counselling. The social worker shares the function of case manager with these professionals. The psychiatrist provides psychiatric consultation and medications; however, the role of the social worker in this mental health setting was to be aware of diagnosis and medication information in order help clients access the doctor when necessary. With segmented roles in a hospital setting, and especially in medical departments outside of psychiatry, other professionals may not see individual *emotional* assessment or problem solving as a function of the social worker (Cowles & Lefcowitz, 1992). In the I.C.A.T.S. team the social worker can provide input at team meetings; however, it was not within the role of a social worker to provide individual treatment.

When working within the multi-disciplinary team it was expected there would be more diverse viewpoints about treatment; however, team members had more in common than they had differences. In terms of counselling approaches used, some appeared to favour different approaches such as the psychodynamic approach, yet all members had an open mind to new models. On the occasion where team members would review and discuss literature articles it was observed that the team would usually agree to approaches that are less intrusive and support values of client dignity and respect. Social workers in

some medical departments note a preference by some professionals for a medical model over the biopsychosocial model (Cowles & Lefcowitz, 1992); this has not been the case in the I.C.A.T.S. unit. Similarities amongst team members exist more so in the I.C.A.T.S. unit where functions overlap, and workers "share a common core of interviewing and counselling skills" (Kirst- Ashman & Hull, 1999).

One advantage social workers had in the hospital setting was the support for the social work profession. Social workers in the outpatient services meet regularly with other social workers in the hospital in adolescent mental health services, the general mental health areas, and the social work council that oversees social work in all other hospital programs. In this forum the writer was able to see the other clinicians model the process of applying new approaches in practice. They discussed their training in a new approach and practiced new techniques with their volunteer co-workers.

Implications for Social Work Practice

Acquiring a broad skill base to address client systems is central to the practice of social work (Kirst- Ashman & Hull, 1999). In this practicum the writer acquired skills in case management, group modality and family modality approaches. Case management, solution-focused and psychoeducational interventions guided by social work theory and research has directed the work in this practicum.

The practice of social work is unique in a multi-disciplinary team as social workers utilize a "person-in-the-environment" perspective. This practicum involved addressing the adolescents' and families' needs within the structural environment and the inherent systems in the lives of families with adolescents who have mental health concerns. The family environment was addressed through case management that

provided necessary resources in helping both parents and adolescents with the task of re-integration into the mezzo environment after in-patient hospital treatment. Solution-focused interventions were based in a strengths approach to enhance collaboration and co-operation within families. The psycho-educational approach further benefited this population as it promoted supportive parent education that was geared to helping parents through techniques that promoted understanding, respect and dignity of teenagers.

When considering interventions for clients, the social worker must consider the "fit-of-service" in addressing the unique needs of clients. Implementing the parenting group provided an adjunct intervention to case management. Being able to see how these different modalities in a role-based case management model serve to meet the unique needs for different families was essential in the practice of social work.

Summary

The objectives of this practicum were to: learn solution-focused and case management interventions with families; develop assessment skills, plan and intervene in a psycho educational parenting group; use evaluation to inform practice; and learn the role of a social worker in a multidisciplinary team setting.

The writer has benefited immensely in this practicum as her understanding and skill base were greatly enhanced. She increased working knowledge and understanding in the areas of psychoeducational theory and of the different approaches to solution-focused therapy in family interventions. Learning occurred in case-management by co-ordinating different interventions that met the unique needs of clients, and valuable experience was gained in implementing an additional modality of parent group psychoeducation to enhance program services. Another benefit was the experience

gained in obtaining feedback to guide practice, such as the value of the variety of ways to collect information and barriers to obtaining measurement in a practice setting. This included becoming acquainted with standardized measures and their fit in a clinical setting; as well as learning how different types of measures and observations each provide a different perspective in the clinical evaluation process. The writer benefited by increasing knowledge and skill in a social work capacity with the population of adolescents who experience mood disorders.

FOOTNOTES

[1] The term counselling and therapy are interchanged throughout the entire report and do not refer to any different interpretation.

[2] Questions 2-12 are based upon the Client Satisfaction Questionnaire – 8 (Larsen, Attkisson, Hargreaves, & Nguyen, 1979) and have been modified to fit the context of the group format or to inquire into additional areas of concern.

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APPENDICES

APPENDIX A

Participant Consent Form

I am a Master of Social Work student from the Faculty of Social Work, University of Manitoba. As part of my training I am completing a practicum in Case Management at the Child and Adolescent Mental Health Program at the Health Sciences Centre. By signing this consent you are agreeing to participate in family or group therapy and acknowledging that I have explained the practicum to you.

If you agree to participate in the practicum you will be asked to evaluate the experience at the end of the counselling sessions.

Participation in the practicum is completely voluntary and you may withdraw or refuse to participate at any time without consequences or penalty. Should you refuse or withdraw from participation, services from the Health Sciences Centre will not be affected in any way.

Information or case scenarios gathered during this practicum may be published or presented in a public forum, however, no identifying information will be included.

As part of my education/training Brad Brown, M.S.W. and my faculty advisor, Dr. Brenda Bacon will provide supervision.

Any questions regarding this practicum may be directed to Susan Kytaychuk (   ) or the faculty advisor, Dr. Bacon (474-8454), or Brad Brown (787-3438).

Thank you for your participation.

Name of Participant	Signature of Participant	Date

APPENDIX B

Consent for Videotaping
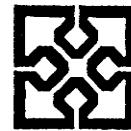
Health Sciences Centre

CONSENT TO PATIENT PHOTOGRAPHY

Date:

Ward:

Full Name:

Year of Birth:

Hospital Number:

Physician:

In the interests of my treatment and for medical science generally, the members of the staff and agents of the Health Sciences Centre are hereby authorized to take and cause to be taken and to exhibit and cause to be exhibited, photographs, video and sound recordings of me.

The present consent is given upon the condition that the said photographs, video and sound recordings shall be used for diagnostic and therapeutic and/or teaching and scientific purposes only, including publication in scientific and professional publications and exhibitions to scientific and medical audiences.

I acknowledge that I am not entitled to any remuneration in respect of the photographs, video and sound recordings or the subsequent use of same, and I further acknowledge that the sole right to copyright and reproduction of such is with the Health Sciences Centre.

I hereby expressly waive any and all claims which I might at any time have, or pretend to have, against the said Hospital, its employees and agents, in any manner whatsoever relating to the said photographs, video and sound recordings.

SIGNED at .... this .... day of .... 19 .....

....
(Signature of Patient/Parent/Guardian)

....
(Witness/Doctor)

CSQ-8

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How would you rate the quality of service you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
Yes, they helped	Yes, they helped a great deal	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

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APPENDIX D
Modified Version of Client Satisfaction Questionnaire-8
For The Parenting Group

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How would you rate the quality of service you have received:

4	3	2	1
Excellent	Good	Fair	Poor

2. To what extent has our group met your needs?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

3. If a friend were in need of similar help, would you recommend our group to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

4. Has the group helped you to deal more effectively with your adolescent?

4	3	2	1
Yes, they helped	Yes, they helped a great deal	No, they really didn't help	No, they seemed to make things worse

5. Please rate how important you found the following topics:

   a. Mental Health & Illness

1	2	3	4
Poor	Fair	Good	Excellent

b. Adolescent Development

1	2	3	4
Poor	Fair	Good	Excellent

c. Health and Unhealthy Family Characteristics

1	2	3	4
Poor	Fair	Good	Excellent

d. Tools for Communication

1	2	3	4
Poor	Fair	Good	Excellent

e. Control Battles with Teens

1	2	3	4
Poor	Fair	Good	Excellent

f. Stages of Change

1	2	3	4
Poor	Fair	Good	Excellent

g. Making Agreements

1	2	3	4
Poor	Fair	Good	Excellent

h. Community Resources

1	2	3	4
Poor	Fair	Good	Excellent

6. Which topics would you like to see more time spent on?

7. Which topics would you like to see less time spent on?

8. Were there any topics you felt should have been covered?

9. Please rate the following:

   a. Group facilitation of the discussion

1	2	3	4
Poor	Fair	Good	Excellent

   b. Material was presented in an interesting and informative way

1	2	3	4
Poor	Fair	Good	Excellent

   c. Handouts

1	2	3	4
Poor	Fair	Good	Excellent

10. What part of the program was most helpful to you:

_____

_____

_____

_____

_____

_____

11. Please indicate how we could improve our program:

_____

_____

_____

_____

_____

_____

12. In an overall general sense, how satisfied are you with the group?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

Any Other Comments:

_____

_____

_____

_____

_____

_____

_____

APPENDIX E

FAM III - Family One

APPENDIX F

APPENDIX G

FAM III Family Two Daughter

APPENDIX H

FAM III Family Two Mother

Legend: Before — After

(Y-axis labels: Family Problem, Average Range, Family Strength)

(X-axis categories: Overall, Task Acc., Role Perf., Comm., Affect Exp., Involvement, Control, Values/Norms, Social Des., Denial)

APPENDIX I

FAM III Family 4

APPENDIX J

FAM III Family 5

APPENDIX K

FAM III Family 6
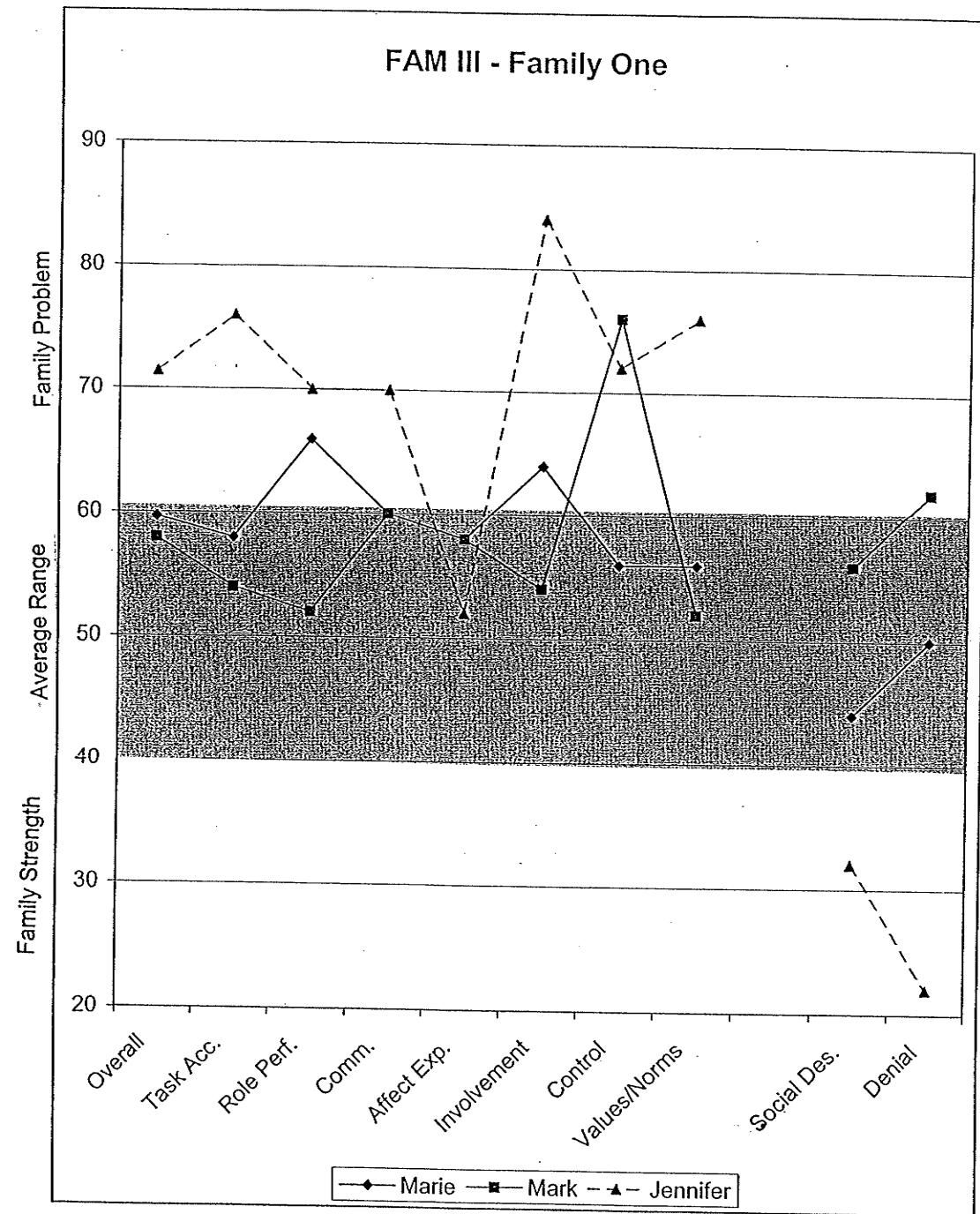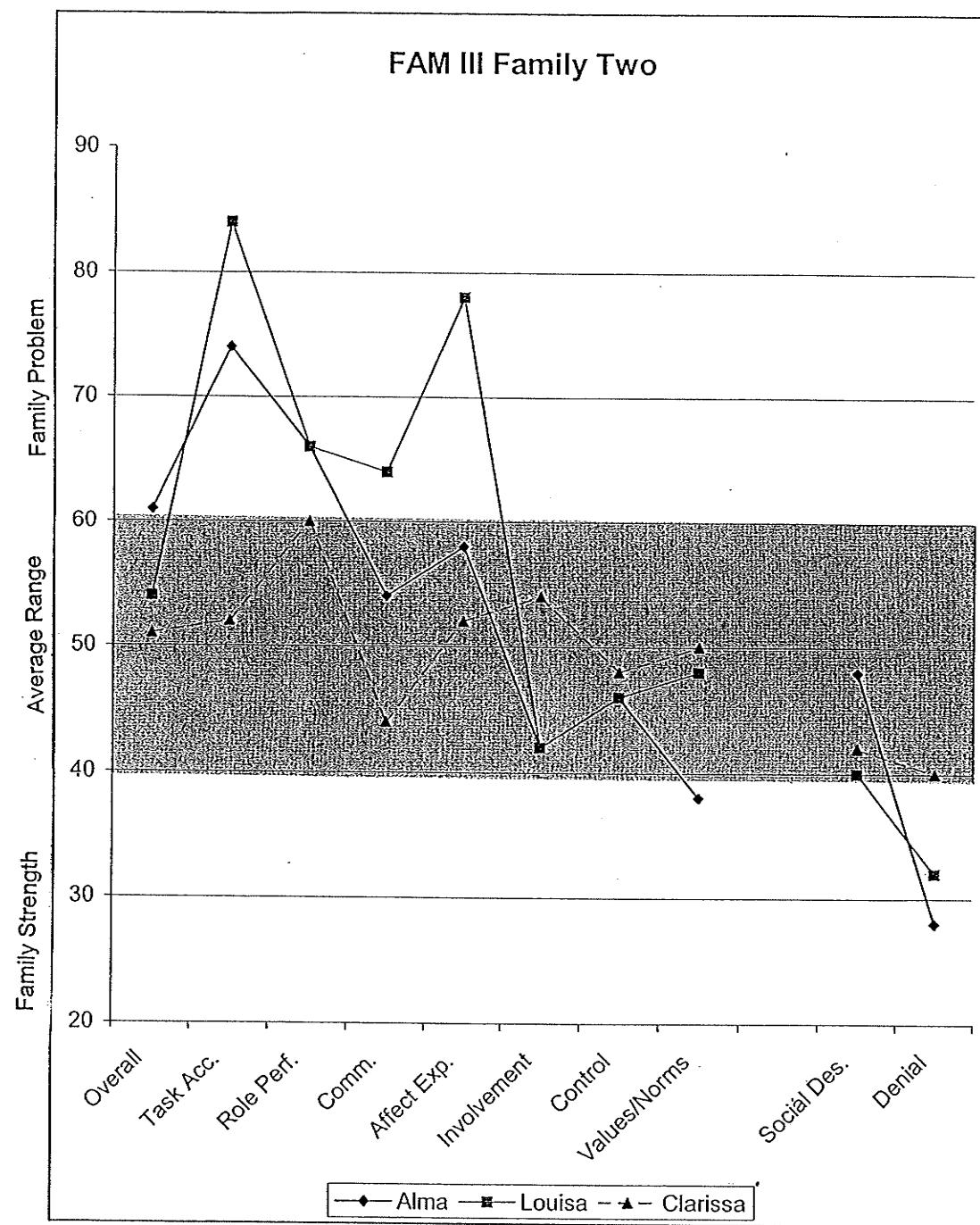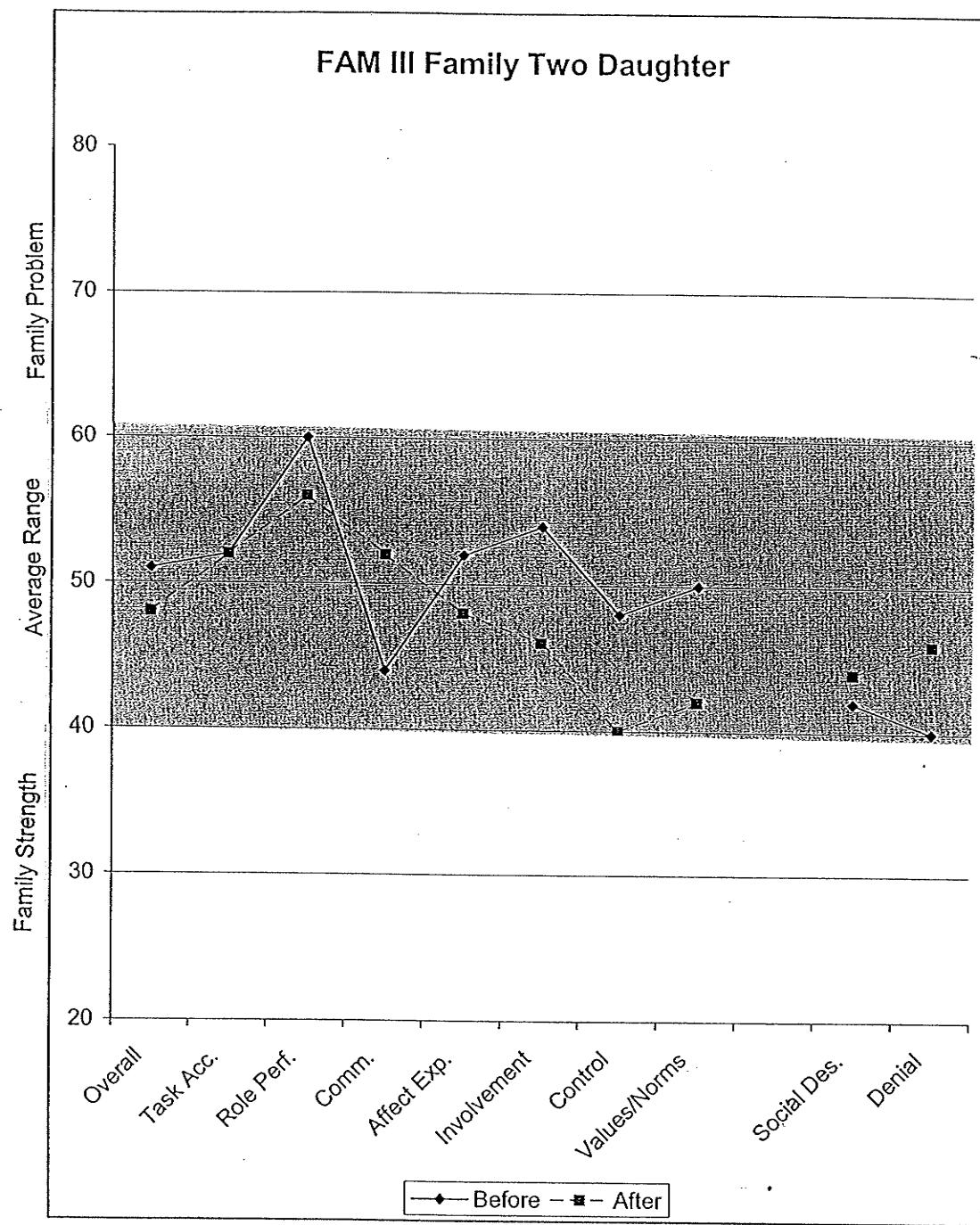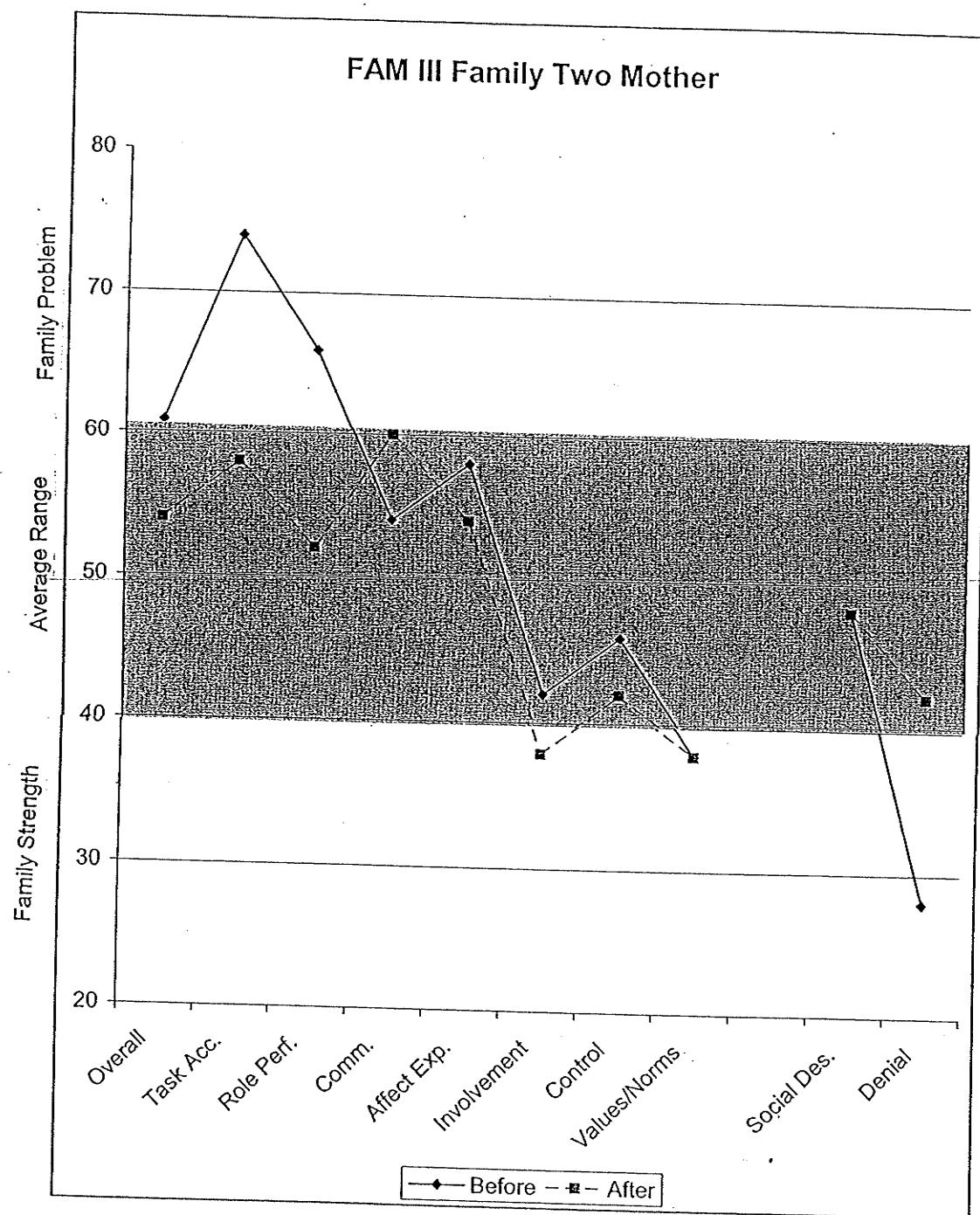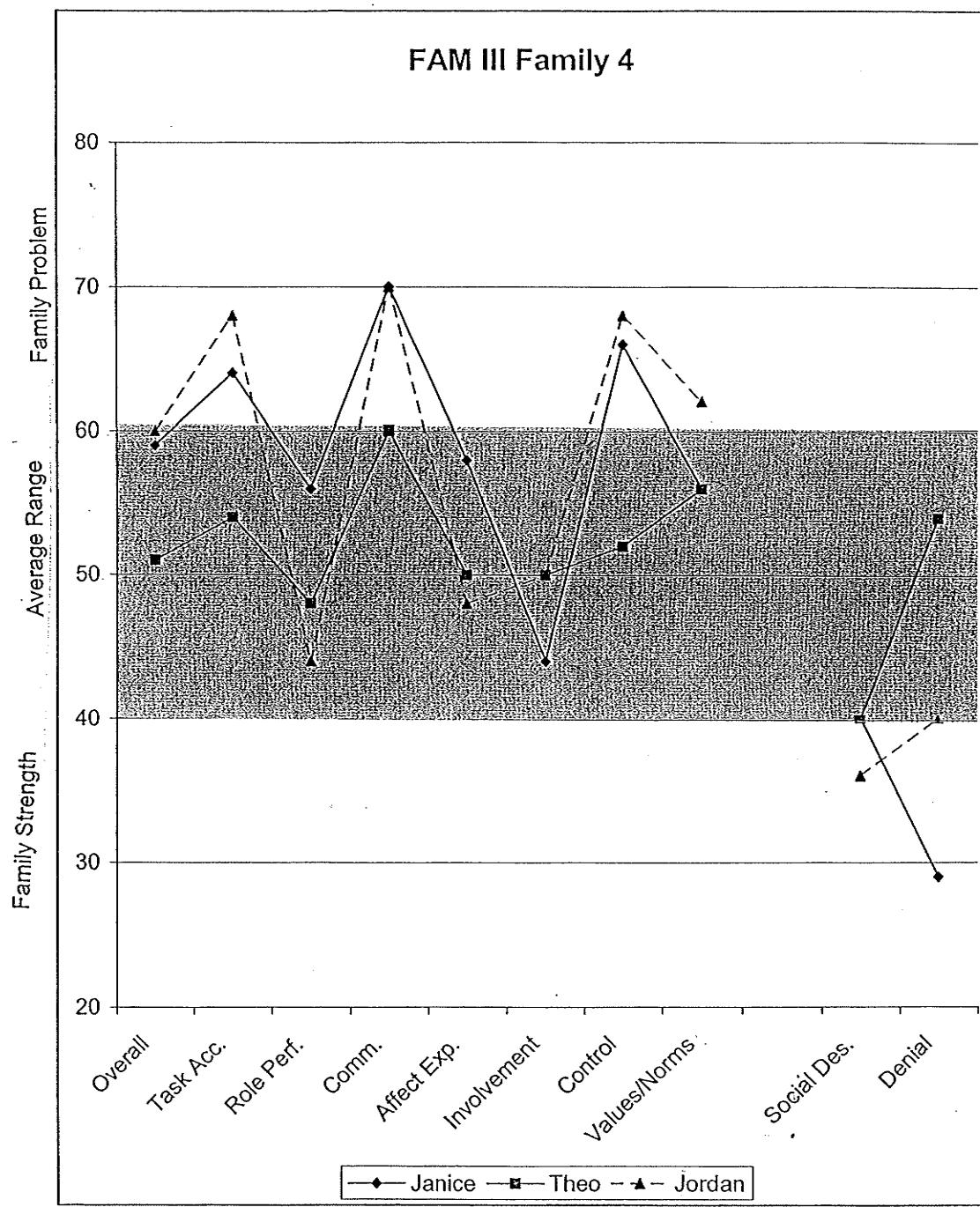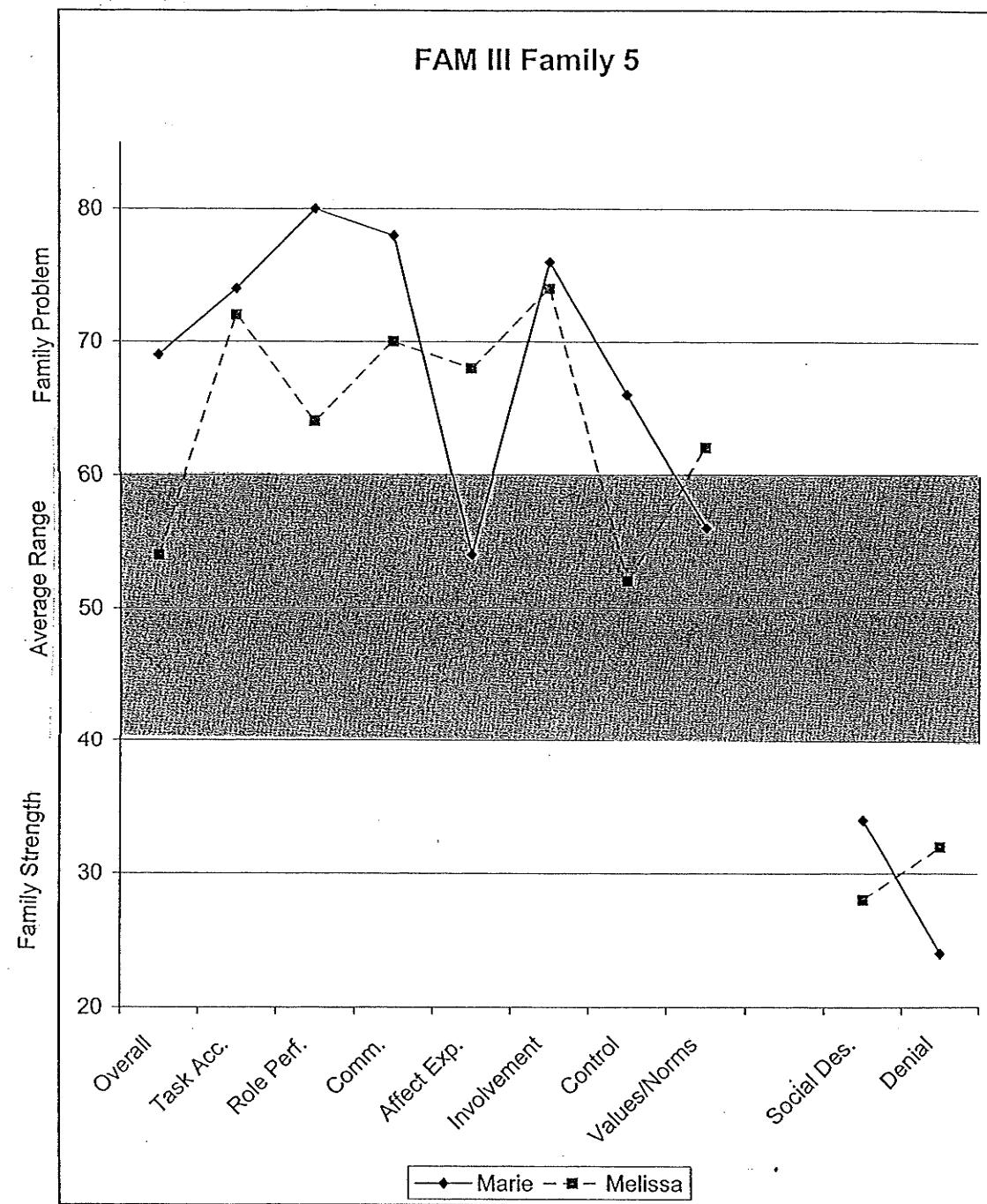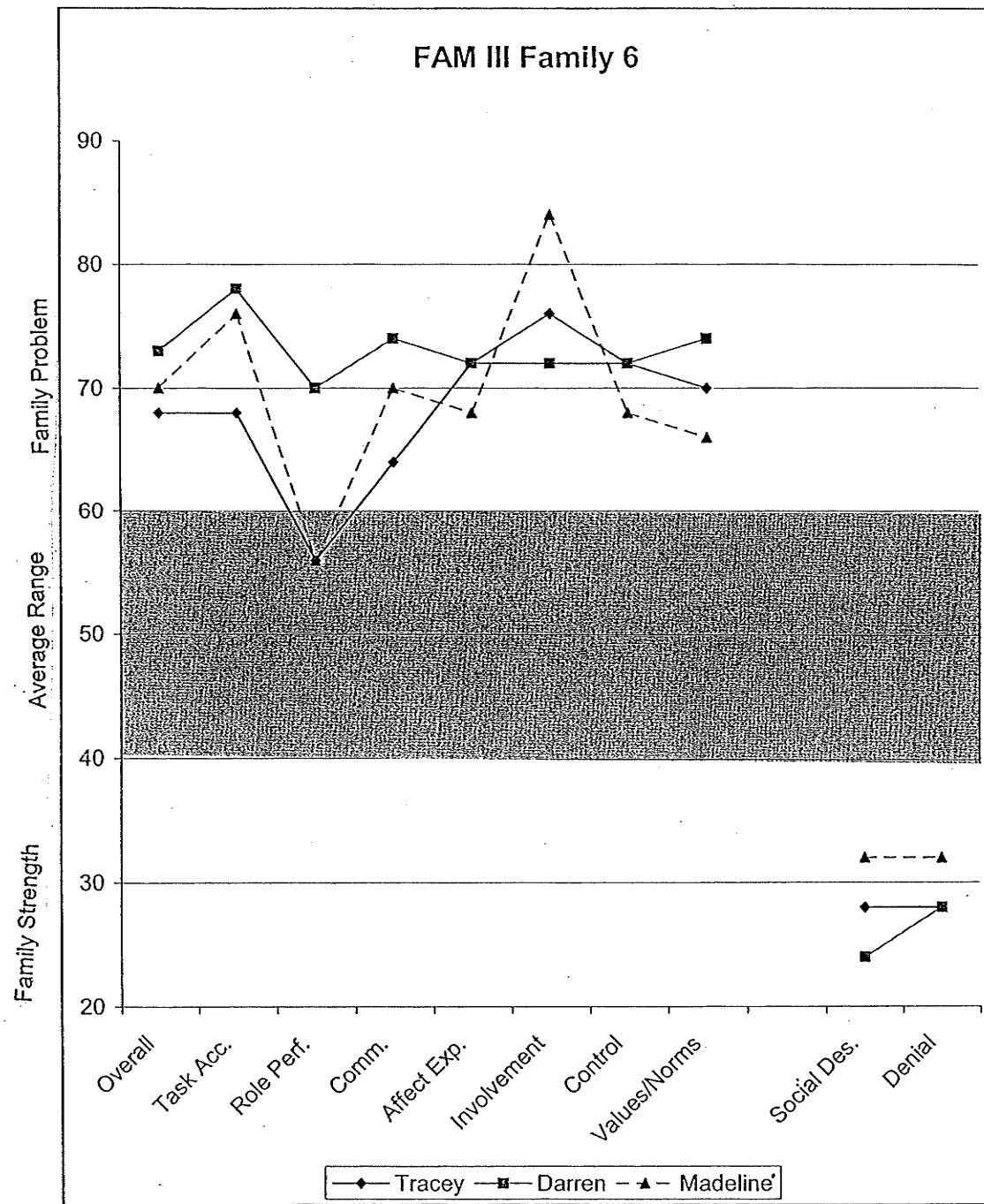
A Parent's Educational Support Group

Course Dates:
Thursdays

March 20 – May 1 /2003
Time:
Room: Child & Adolescent PZ

First Session: Meet in Waiting Area
Closed Group
Space is Limited

For more information
Please call Susan Kytaychuk at
787-3643

A project held by
the Health Sciences Centre
and
The University of Manitoba

**Intensive Child and Adolescent
Treatment Services (I.C.A.T.S.)
Health Sciences Centre
Winnipeg, Manitoba**
771 Bannatyne

A New Approach to Strengthening Your Relationship with Your Teenager

A parent's role dramatically changes as their son or daughter enters adolescence. In search for their own identity, teenagers face many decisions and influences from the culture outside of your family. Building an honest and influential relationship with your teen can be difficult.

This educational workshop offers a safe and supportive opportunity for parents to come together as a group; knowledge on mental illness and parent-teen relationships will give you the tools to necessary to build a stronger relationship with your teenager.

Program Outline

✦ **Week One** - Introductions. Understanding mental illness and treatments.

✦ **Week Two** - Understanding your teen: Adolescent development.

✦ **Week Three**- Identifying healthy family characteristics.

✦ **Week Four** -Improving communication with your teenager.

✦ **Week Five** - How to lose influence over your teen.

✦ **Week Six** - Tools to build a stronger relationship.

✦ **Final Session** - Community resources: Accessing help during crisis.

Who will be attending?

Parents who have a teenage son or daughter who are receiving treatment in the ICATS program through the Psychealth Centre.

This group will be facilitated by a Nurse from the ICATS program and a Masters of Social Work student from the University of Manitoba.

There are no fees involved, as this program is covered by Manitoba Health. This project is in conjunction with a Masters of Social Work practicum experience with the University of Manitoba. Your attendance at each meeting is important. You will be asked to fill out a survey at the end of the final session.

APPENDIX M

Group Content

Session One – Group Introductions and Understanding Mental Illness

The topic of mental health and illness was written and presented by Lisa Magalas, R.P.N. The information was based on the work of Dr. Michael Bradley (2002). The writer presented the information on the impact of illness on families that was based on the work of Lefly (1997). The following briefly outlines the information that was covered.

Four Areas of Adolescent Life:

1. Acting out behaviours

    a. Struggle for independence and autonomy: testing limits

    b. Moodiness: normal moodiness, symptoms of depression, guidelines for suicidal thoughts and behaviours

    c. Struggles with food

    d. Anxiety: symptoms of anxiety

2. Types of treatment: psychotherapy, group and family therapy, and medication

3. Two tasks for parents: one) listen without making judgements; and 2) see teenager as a human being first apart from the illness.

4. Impact of Mental Illness on Families

    a. Impact on families: sources of stress, emotional suffering, blame and demands on family time (Hatfield, 1978; Lefley, 1996).

Session Two: Adolescent Development

1. Development:

   a. The teenage brain: Based on the research of Dr. J Giedd and Dr. D. Yurgelun-Todd (Spinks, 2002) that examines how the teenage brain undergoes dramatic growth and development resulting in using different parts of the brain for recognizing fear, organizing information, decision making and consequences.

   b. Family Development: a brief overview of the family life cycle including commentary on the impact of cultural diversity, divorce and poverty (Carter & McGoldrick, 1999).

   c. Adolescent Development: examined developmental tasks of teenagers in the context of identity building (Kirshenbaum, 1991; and Bradley, 2002).

2. Acting-Out Behaviours: provides a framework for gauging mild, moderate and severe behaviours and guidelines for intervening (Miccuci, 1998).

Session Three: Healthy Family Characteristics

1. Families on a continuum: the session started with a diagram of a simplified version of a bi-directional continuum by Olson (1991) to explain family characteristics into two groups 1) balanced and extreme forms of *structure* and 2) balanced and extreme forms of *flexibility*.

2. Types of families: Coloroso's (1994) three types of families: brick-wall, backbone and the jellyfish families was used to further describe families in terms of rules, consequences, negotiation, and dealing with emotions within these three different types of families.

3. Additional Handouts: The first handout (when and when not to search a teenager's room) was based on the arguments of Bradley (2002). The second handout, *Basic Principles of Fair Fighting* was compiled by Brad Brown (unpublished).

Session Four: Improving Communications With Your Teenager

1. Exercise: the purpose of this exercise is for members to increase their awareness between good and poor listening. Members divide into groups of two. One person is the parent and the other is the teenager. The parent will listen to the teenager in two different times: first, with poor listening skills and second, with good listening skills. Next the members switch roles so everyone gets a chance to be the teenager noticing the impact of good or poor listening. A discussion is held to summarize the impact of both styles. The exercise was based on the work of Ramsay, Tanney, Lange, Tierney, Kinzel, and Turley (1999).

2. Expert listening tools: this was titled to acknowledge that anyone can learn these skills. Six listening tools included five aspects of communication from Olson's circumplex model (1991): empathy, active listening, tracking and staying on topic, respect and regard, "I" statements; and Selekman's (1993a) importance of acknowledging people can have different meanings of one event.

Session Five: How to Lose Influence Over Your Teen

1. Exercise: *Treating Family Like Friends* is the work of Karen Raytor (Metcalf, 1998). The purpose of this exercise is to emphasize the positive emotional connection, which occurs more easily in friendships and can get lost when parents are concerned with consequences that can turn into a control battle. This is not to

imply being a friend to teens but to be *friendly*. In this exercise parents compare how their reactions can differ between their friends and their teens when helping out with similar problems.

2. Way to Lose Influence Over Your Teen: this educational piece focused on how control battles can escalate and destroy relationships and trust can be rebuilt through agreements.

    a. Ten Reasons Why Control Battles Do Not Work (Colorosso, 1994; Kirshenbaum, 1991; Mellody, 1989)

    b. Laying Down The Law vs. Making Agreements (Kirshenbaum, 1991)

    c. Tips For Making Agreements (Bradley, 2002; Colorosso, 1994; Kirshenbaum, 1991).

Session Six: Tools For Build a Strong Relationship

1. Tough Issues: this topic looked at the stages of change (Prochaska & Diclemente,1984). Handouts from the Addictions Foundation of Manitoba that applied this model in a parenting perspective were provided, i.e. the parent's task when a teenager is in denial with alcohol use.

2. Makings Agreements: This discussion continued with the theme of building trust and looked at different approaches of agreements and gave examples.

    a. Negotiation Model #1 (Bradely, 2002)

    b. Negotiation Model #2 (Kirshenbaum, 1991)

    c. Examples of Agreements (Bradley, 2002; Kirshenbaum, 1991)

Session Seven (Final Session): Community Resources

1. Community Resources: a discussion was held that drew on the knowledge and experience of clients by asking them to list the resources they knew about. Handouts were given while a discussion summarized a list of community resources

2. Evaluation: verbal feedback was obtained from participants. This was followed by the CSQ-8 which was tailored for the group experience

APPENDIX N

1. How would you rate the quality of service you have received?

Parent One	4-Excellent
Parent Two	4-Excellent
Parent Three	3-Good

2. To what extent has our group met your needs?

Parent One	4-Almost all of my needs were met
Parent Two	4-Almost all of my needs were met
Parent Three	3-Most of my needs were met

3. If a friend were in need of similar help, would you recommend our group to him or her?

Parent One	4-Yes, definitely
Parent Two	4-Yes, definitely
Parent Three	4-Yes, definitely

4. Has the group helped you to deal more effectively with your adolescent?

Parent One	3-Yes, they helped a great deal
Parent Two	3-Yes, they helped a great deal
Parent Three	3-Yes, they helped a great deal

5. Please rate how important you found the following topics:

	Mental Health & Illness	Adolescent Development	Healthy & Unhealthy Families	Tools For Communication
Parent One	3- Good	4-Excellent	3- Good	4- Excellent
Parent Two	4- Excellent	3-Good	3-Good	4- Excellent
Parent Three	3- Good	3-Good	3-Good	4- Excellent

	Control Battles with Teens	Stages of Change	Making Agreements	Community Resources
Parent One	4- Excellent	4- Excellent	4- Excellent	4- Excellent
Parent Two	4- Excellent	3-Good	4- Excellent	4- Excellent
Parent Three	3- Good	3-Good	3-Good	4- Excellent

6. Which of the topics would you like to see more time spent on?

Parent One	Blank
Parent Two	Healthy & unhealthy family characteristics. Making agreements. Mental health & illness.
Parent Three	Discuss making agreements in the first few sessions. Continue to leave time each week for parents to talk about individual situations with our teenagers.

7. Which topics would you like to see less time spent on?

Parent One	Blank
Parent Two	Blank
Parent Three	General advice on dealing with teens.

8. Were there any topics you felt you should have been covered?

Parent One	Blank
Parent Two	Blank
Parent Three	More time on extreme behaviours.

9. Please rate the following:

	Group Facilitation of the discussion	Material was presented in an interesting and informative way	Handouts
Parent One	3- Good	4-Excellent	4-Excellent
Parent Two	3- Good	3-Good	3-Good
Parent Three	3- Good	3-Good	4-Excellent

10. What part of the program was most helpful to you?

Parent One	Listening and communication skills. Teenage Development
Parent Two	Mental development, role playing, making agreements
Parent Three	Pamphlets on what to do in a crisis situation

11. Please indicate how we could improve our program:

Parent One	Blank
Parent Two	Introduce a role-play in every session
Parent Three	1) Pamphlets first week 2)how to deal with extremes 3)how to deal with the duration, intensity and extremes of denial our kid hurting themselves4)how to deal with short-term & long-term crisis situation(denial & tunnel thinking)

12. In an overall general sense, how satisfied are you with the group?

Parent One	4-Very Satisfied
Parent Two	4- very Satisfied
Parent Three	3- Mostly Satisfied

Any other comments?

Parent One	I wish we had this parenting classes when we were starting therapy. I believe it would have help us get better sooner or more understanding.
Parent Two	The survey should be done at the end of each session, instead of at the end of the program. It is very hard to remember what happened seven weeks ago.
Parent Three	Blank