THE APPLICATION OF EMOTION FOCUSED THERAPY AND BOWEN FAMILY SYSTEMS THEORY IN FAMILY THERAPY WITH ADOLESCENTS

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

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TABLE OF CONTENTS

Integration of Theories

CHAPTER 4: INTERVENTION

CHAPTER 5: THE PRACTICUM

Brief Exploration of Selected Case Studies

In-depth Exploration of Case Studies

ABSTRACT

This practicum focuses on family therapy with adolescents and their families who have experienced trauma, separations and/or were having difficulties in the transition through adolescence. Traumas and separations can have significant impact on family relationships and attachment between family members. This can be compounded by the transition period throughout adolescence. The purpose of this practicum is to ascertain whether Emotion Focused Therapy and Bowen Family Systems Theory are appropriate interventions to be used in this context. The use of Emotion Focused Therapy in combination with Bowen Family Systems Theory has interesting implications and usefulness with this population. An in-depth assessment of the family system and a strong therapeutic alliance is required in order to facilitate the use of this approach. The evaluation instruments used in combination with the writer's clinical assessment were the Family Assessment Measure III General Scale (FAM-III) and a Post-intervention Qualitative Questionnaire. Two case examples are explored in-depth, and there is brief discussion of three other families seen during this practicum.

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CHAPTER 1: OVERVIEW AND INTRODUCTION

The transformation of the family system in adolescence requires adaptations in both family structure and organisation (Preto, 1999). The family is transformed from a system that protects and nurtures the young child into one that prepares the adolescent for the world of adult responsibilities and commitments. This shift may be signalled initially by the adolescent's physical maturity, but it is often paralleled by parents' entry into mid-life and grandparents' entry into old age. Although for most families this transition involves relatively little family dysfunction, there are cases where families encounter more serious problems. Transitioning in and through adolescence involves accepting the loss of the dependant child, loss of childhood self and the loss of the family as the primary source of love and affection.

Practicum Focus

This practicum formed the basis for extending my knowledge in working with families within a clinical setting. The intervention involved family therapy for adolescents aged 12-19 years of age and their families. Clients presented with a variety of problems stemming from childhood/adolescent trauma and separations and/or problems encountered during the transition into and through adolescence. The intervention incorporated the approach of Emotion Focused Therapy (EFT)[1] and Bowen Family Systems Theory, with EFT being the primary intervention. The objective of this intervention was two-fold: firstly, working with families in order to decrease the presence of the presenting problems and secondly to allow the application of theoretical knowledge in clinical practice.

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[1] In the literature "EFT" applies to work with individuals and couples and "EFFT" refers to work with families. For the purpose of this practicum EFT will be used throughout.

Learning Goals

There are some specific learning goals on which this practicum was focused:

1. Increasing knowledge of Bowen Family Systems Therapy and incorporating it within the therapeutic intervention.
2. Increasing knowledge of EFT and incorporating it within the therapeutic intervention.
3. To learn if an integration of Bowen Family Systems Theory and EFT was appropriate for working with troubled adolescents and their families.
4. Developing and practicing skills to work within a multidisciplinary setting
5. Increasing knowledge and practical skills to work with families who presented with multiple problems and diverse backgrounds (e.g. culturally, economically).
6. Increasing knowledge of various theoretical orientations by viewing family therapy led by other professionals.
7. Developing confidence in being the primary therapist.
8. Developing the skills to distinguish between content and process when doing family evaluations

It is very important that social workers learn to apply concepts of family systems theory into clinical interventions. We must learn to apply both concepts of family systems, theoretical knowledge and intervention skills in order to meet the needs of families. By focusing on the family system, knowledge surrounding process and change as it relates to families with adolescents can be accrued. This knowledge can then be extended to working with a variety of families experiencing a range of family functioning problems and varying family life cycle change.

Intervention

Emotion Focused Therapy

EFT is a synthesis of experiential and systemic approaches (Johnson & Talitman, 1997). It has been used predominantly with couples, although with recent application to the context of family therapy (Johnson, 1996). It is a relatively new intervention which has well outlined steps and techniques. There are nine steps and numerous techniques that are used throughout the three defined stages: stabilization, building self and relationship capacities, and integration (Johnson & Williams-Keeler, 1998). EFT does not have a well-outlined theory, but instead derives much of its understanding from attachment theory.

Although research is just beginning to be gathered, preliminary results show that it is an effective intervention with couples experiencing marital problems (Johnson & Greenberg, 1985). EFT has been applied to the family context, and has documented success with adolescents who are bulimic (Johnson, Maddeaux, & Blouin, 1998).

Bowen Family Systems Theory

Bowen theory is predominantly a theoretical model which evolved from psychoanalytic principles and practice (Nichols & Schwartz, 1998). Integral to the theory are the concepts of togetherness and individuality, differentiation of self, triangulation, nuclear family emotional process, emotional cut-off, family projection process, multigenerational transmission process, and sibling position. As opposed to EFT, Bowen theory did not focus as much on techniques. However, there are two specific ones which are normally incorporated into interventions - genograms and I-positions.

Evaluation of Practicum

This practicum was evaluated pre and post intervention by using the Family Assessment Measurement General Scale (FAM-III). In addition, the Post-intervention Qualitative questionnaire was done in the last conjoint family session. The information helped to gather insight into family functioning, the helpfulness of the intervention, and possible avenues for improvement. The practicum was also evaluated by using practitioner logs, video recording of family sessions, and supervision/committee feedback and consultation.

CHAPTER 2: AN OVERVIEW OF ADOLESCENT DEVELOPMENT

Adolescence as a Family Life Cycle Stage

Adams, Gullota, and Markstrom-Adams (1994) identify a variety of different definitions of adolescence. This ranges from physiological definitions, to cognitive, sociological, chronological, eclectic, and a "learner's permit" definition. Regardless of the definition and criteria used to identify the onset of adolescence, many would agree that it is marked by a variety of cognitive and physiological changes. Carter and McGoldrick (1980) see this family life cycle stage of the "unattached young adult" as a determining factor of whom and when they marry, and all succeeding stages of the new family life cycle. The adequate or inadequate completion of the primary task of coming to terms with his or her family of origin will also influence subsequent life cycle stages. This stage requires the adolescent to separate from their family of origin, while still having ties to his or her family. In this light, it is a cornerstone; a time to develop personal life goals, and to be a "self" before joining with another to form a new family subsystem.

There is some discrepancy over the view that adolescence is a stormy period (Bruggen & Davies, 1981). Some studies have shown that most adolescents negotiate this transitional period without severe problems or any marked conflict with parents. Indeed, "the average family seems to weather the storm, adapt to it, and grow" (Carter & McGoldrick, 1980, p. 155). However, despite the fact that most adolescent's traverse this time without irreparable scars, it is also a time when mental illness can develop (Ackerman, 1980). This is probably due to the biological fragility of the adolescent combined with the inevitable decreased contact of the adolescent with their family. The

adolescent may change residences or become highly involved in outside activities. The family may not be able to totally comprehend or adjust to these new changes. The loss of the family as an emotional support can lead to breakdown.

The transition into adolescence requires various role changes (Bruggen & Davies, 1981). The developmental issues that occur in adolescence can be divided into three general phases: early adolescence (ages 11-13), middle adolescence (ages 14-16), and late adolescence (ages 17-19) (Micucci, 1998). The three stages and the accompanying issues are as follows:

Early Adolescence	Middle Adolescence	Late Adolescence
• Adjusting to pubertal changes	• Handling sexuality	• Consolidating an identity
• Learning to use new cognitive capacities	• Making moral decisions	• Experiencing intimacy
• Finding a place among peers	• Developing new relationships with peers	• Leaving home
• Dealing with gender-related expectations	• Balancing autonomy and accountability	

(Micucci, 1998)

Despite this typical pattern of developmental challenges across adolescence, it is important to keep in mind the context and definition of normality, asynchronicity in development, and the interaction between adolescent and parental developmental issues (Micucci, 1998). It is difficult to be restrictive in a definition of adolescence such that any deviation from norm is considered pathological. Normality in this light poses a paradox. Any definition or discussion of normality is influenced by cultural expectations. Secondly, the course of adolescent development is not necessarily linear or coordinated in all areas. Lastly, the adolescent is not the only individual in the family system who is

going through developmental changes. Development occurs across the life span and parents are facing developmental challenges as well.

In addition to developmental issues for the adolescent there are role changes that affect the family. Three adolescent role changes that directly impact on the family are: he or she is becoming independent and may leave the family, they are in the process of forming sexual relationships, and they may become a parent themselves (Bruggen & Davies, 1981). The family must change in response; particularly, the parents must undergo a complimentary role change.

The adolescent's demand for greater independence tends to precipitate structural shifts and renegotiation of family roles in at least three generations of relatives (Preto, 1999). During this life cycle stage it is not uncommon for grandparents to redefine their relationships, spouses to renegotiate their marriage, and siblings to question their position in the family. These demands are often so strong that they also serve as catalysts for reactivating unresolved conflicts between parents and grandparents, or between the parents themselves; thus setting triangles in motion. Earlier patterns of relating in one's family of origin are often repeated in order to resolve conflicts between adolescents and parents.

There are four basic ways that the family with an adolescent may present themselves in therapy (Ackerman, 1980):

1. Symptomatic behaviour of the adolescent.
2. Troubles in the marriage.
3. Symptomatic behaviour of a sibling.

4. Symptomatic behaviour of one of the parents (frequently with extended family problems).

It is important to remember that regardless of the way the family presents, all four of these presentations are involved to some degree. When the clientele includes children and adolescents, a shift from individual to family therapy is usually indicated. This shift was founded on the notion that focusing on the individual who is manifesting a problem is misguided (Wachtel, 1994).

Attachment and Adolescence

The message that parents receive from society is that during adolescence the parent(s) should distance and separate from the adolescent in order to break the attachment bond. However, there is evidence to suggest that the role of the parent as a provider of safety continues well into the child's adult life (Levitt, 1991). Adult children continue to receive emotional and instrumental support from their parents. Despite this, there is limited data to illuminate the course of parent-child attachment beyond infancy. However, what is known is that the presence of a least one close relationship adds greatly to an individual's well being. At any point in the life span, attachment relationships provide the individual with a secure base from which to encounter the inevitable stresses of daily life. A secure base includes two interlocking behaviour systems: the attachment system and the exploratory system (Bowlby, 1979). The attachment system protects the child from harm, while the exploratory system allows the child to develop and learn instrumental competence.

It is common that the histories of psychiatric patients are riddled with negative attachment-related experiences such as loss, abuse, or conflict (Goldberg, 2000).

Empirical studies of adolescent and adult psychiatric populations have found a very low incidence of autonomous attachment. For example, a study done by Adams, Gullota, and Markstrom-Adams (1995) found that only 16% of psychiatric patients aged 13 to 19 were judged to be autonomous, compared to 50% in normative samples (cited in Goldberg, 2000). Furthermore, a meta-analysis of studies of clinical populations confirmed that insecure attachment patterns were strongly over-represented in adult clinical samples, with only 12-14% being autonomous (van Ijzendoorn & Bakermans-Kranenburg, 1996; cited in Goldberg, 2000). Despite these findings, secure attachment is seen in clinical populations, but is not a guarantee of mental health (Goldberg, 2000).

An additional attachment pattern that makes up a large portion of the clinical samples of adolescents and adults is unresolved attachment (Goldberg, 2000). In most psychiatric samples, unresolved attachment is the most common non-autonomous classification. In a small study of 20 anxiety-disordered mothers, 100% of the mothers were found to have insecure attachments, while 70% of these insecure attachments were unresolved for loss or trauma. In another study by Adam, Sheldon-Keller and West (1995), 52% of 13 to 19 year old psychiatric patients had unresolved attachment (cited in Goldberg, 2000). In most cases this classification was based on severe separations where the adolescent was unwillingly ejected from the family home or placed in residential or foster care. In terms of psychiatric disturbance, insecure attachment is not the primary reason for psychosis (Goldberg, 2000). However, it is a risk factor that operates in concert with other coexisting conditions to decrease or increase vulnerability to psychiatric disorder.

Implications of Trauma on Attachment Relationships

Many adverse psychological outcomes have been related to trauma; these include depression, anxiety, and rumination (Updegraff & Taylor, 2000). In addition to the adverse psychological outcomes, most people derive at least a few benefits from traumatic events, including positive changes in self-concept, beneficial changes in relationships with others, and personal growth and adjustment of life priorities. Research has shown that some of the mechanisms by which individuals reap positive benefits include selective perceptions, selective evaluation, and selective social comparison. In the face of adversity individuals can thrive if they have a strong sense of self, cope actively, are optimistic, and perceive more control over life events. On the other hand, individuals who use more avoidant coping strategies have more pessimistic expectations, have low perceptions of control, and have pre-existing dispositional vulnerabilities are more likely to succumb to the negative effects of traumatic life events, and be more vulnerable to subsequent stress.

The link between trauma and attachment relationships has interesting implications for the presence of Posttraumatic Stress Disorder (PTSD). It has become clearer that trauma is a necessary, but not sufficient precursor to the development of PTSD (Dieperink, Leskela, Thuras, & Engdahl, 2001). Despite the fact that trauma is a significant predictor of PTSD, the National Comorbidity Survey found that only 18% of women and 10% of men developed the disorder after exposure to a traumatic event (Kessler, Sonnega, Bromet, & Nelos, 1995; cited in Dieperink, Leskela, Thuras, & Engdahl , 2001). A study by Dierperink et al. (2001) investigated the relationship between trauma and attachment styles in 107 former prisoner of war veterans. Results

found that 65% of the former prisoner of war veterans reported insecure attachment styles. Furthermore, 42% of those with insecure attachment met the criteria for PTSD.

These studies point to the importance of secure attachments throughout the life span. Important implications for intervention include the development of a secure attachment style to caregivers in order to buffer the effects of trauma and to ward against the development of PTSD. For the population encountered during this practicum, empirically validated research points to the importance of focusing on attachment relationships. One of the main goals of EFT was to strengthen the attachment bond. Theorists such as Bowlby and Ainsworth have discussed the importance of attachment relationships in infancy. Research now has documented the long-standing benefits reaped by the development of secure relationships in infancy.

CHAPTER 3: LITERATURE REVIEW OF EMOTION FOCUSED THERAPY AND BOWEN FAMILY SYSTEMS THEORY

Emotion Focused Therapy

Greenberg and Johnson (1988) developed EFT in response to the lack of clearly defined and validated marital interventions (Johnson, 1996). EFT makes use of the work from Fritz Perls, Satir, and MRI schools of family therapy (Griffin & Greene, 1999). It focuses on emotion as a powerful agent of change, rather than a simple part of the problem of marital distress (Johnson, 1996). In this approach, faulty attachment is seen to lead to suppression of "core" emotions and emergence of secondary reactive emotions, such as defensiveness and coercion (Griffin & Greene, 1999). Although much of the focus of EFT has been its application to couple therapy, it has also been incorporated into family therapy (Johnson, 1996). The assumptions, goals and processes of EFT with families are essentially the same as EFT with couples. This approach differs from the majority of family therapies which focus on interactions between individuals and rarely address the emotions that are occurring within individuals. The focus on emotions is particularly important in families, due to their part in organizing and regulating social interactions within the family system.

It is important to note at this time that EFT can be used with multiple intervention modalities. For example, Sue Johnson uses EFT primarily with couples and most recently with families (1996), while Les Greenberg uses EFT with individual clients (Greenberg & Pavio, 1997). Although some of the basic foundation of the theory can be found in each modality, there are some differences in terms of goals, stages, and framework. For example, the stages and steps of EFT with families/couples and individuals differ slightly

in terms of the focus on attachment needs. EFT with couples and families focus on the attachment needs and the interactional process.

Link between EFT and attachment theory

EFT is linked to the theoretical orientation of attachment theory (Johnson, 1996). From an attachment viewpoint, the more securely attached an individual is with his/her attachment figure(s) the easier it is for the individual to act independently and to confidently explore his/her environment. Secure attachment relies on the ability to maintain close supportive relationships, as well as creating and maintaining personal autonomy. Secure attachment and independence are seen as two sides of the same coin, rather than as a dichotomy (Johnson, 1998). Attachment is associated with the ability to handle environmental stresses and improved emotional adjustment (Johnson, 1996). Furthermore, secure connections with others tend to have a positive effect on psychological factors, such as self-efficacy (Bartholomew & Horowitz, 1991). Individuals who are insecurely attached usually have problems with emotional regulation (Johnson, 1998).

Assumptions

There are three basic assumptions of EFT (Johnson, Maddeaux, & Blouin, 1998):

1. Rigid negative interaction patterns maintain problems in relationships. These patterns reflect and create absorbing emotional states of fear, grief, and anger. These emotional states and interactional patterns interact to form compelling family dramas that limit communication and increase insecurity.
2. Family conflicts that result in symptomatic behaviour are most usefully viewed as attachment problems resulting in separation distress. During times of transition and

crisis, insecurely attached adolescents tend to either heighten expressions of anger and distress and aggressively demand reassurance, or disengage and minimize expressions of distress precisely when they need the most support. A key part of EFT is recognizing and validating attachment needs.

3. Emotion is a key element in organizing attachment behaviours and self-regulation, and in the formation of identified schemas. Assessing and reorganizing emotional experiences is the most effective route to new interactional patterns that redefine an attachment relationship and foster the modification of negative self-schemas. This is the most powerful route to create intrapsychic and interpersonal change.

Types of emotions

EFT focuses on accessing primary emotions in order to change interactional positions (Greenberg & Johnson, 1998). Greenberg and Paivio (1997) have found that taking this internal focus, rather than changing the environment, can be self-empowering for the client. Greenberg and Safran (1987) identify three basic emotions - primary, secondary, and instrumental. Primary emotions are the most fundamental, initial emotional responses to situations which can be distinguished from secondary and instrumental emotions (Greenberg & Johnson, 1998). They are action-tendencies that arise in interaction with the environment, and direct people toward or away from objects in the environment (Greenberg & Johnson, 1986). Adaptive primary emotions include feelings such as sadness at loss, anger at violation, or fear at threat (Greenberg & Johnson, 1998). These emotions clearly have an adaptive value and many are highly related to attachment. Included within this category are bodily felt sensations (that when symbolized help to orient us in a complex interpersonal world), and emotional pain

(Bolger, 1996, cited in Greenberg & Johnson, 1998). Bodily sensations may give a higher level of "sense" or a feeling of being on top of the world. Emotional pain may be seen as a holistic system response to system fragmentation and trauma.

In addition to adaptive primary emotions, there are also maladaptive primary emotions (Greenberg & Johnson, 1998). These include fear of desired intimacy, shame at self-expression or revelation, anger at the genuine caring or concern of others, and joy at the suffering of self or others. These maladaptive primary emotions are generally based on pathogenic learning histories of extreme neglect, abuse, or invalidation; thus initially serving an adaptive function. These maladaptive emotions need to be assessed in therapy in order to restructure the core maladaptive emotion schemes to which they are embedded.

Secondary emotions are defined as reactions to identifiable, more primary emotional or cognitive processes (Greenberg & Johnson, 1998). They can either be secondary responses to primary emotions, such as crying when primarily angry, or secondary responses to cognitive process, such as feeling depressed when thinking about failure. Therapy involves distinguishing between primary and secondary emotions, and focusing on the more primary and adaptive attachment related experience. It is important to address the primary emotions because secondary emotions frequently are used to avoid more frightening, shameful, or painful feelings. As opposed to adaptive primary emotions, secondary emotions can lead to destructive interactions and behaviour. The therapist reflects and validates secondary emotions in order to join with the clients and describe the cycle (Johnson, 1998). From here, the responses are expanded in order to access the primary affect.

The third type of emotion is instrumental emotion (Greenberg & Johnson, 1998). This refers to emotions that are experienced and expressed because the individual has learned that they have an effect on others. They may be consciously intended to achieve an aim, or have become habitually learned and are automatic. Instrumental emotions can be understood as roles or social construction. For example, an individual who is inappropriately dressed for an event may display embarrassment which conveys that they are well socialised and know the rules.

Therapeutic Goals

One goal of EFT is to access and uncover key emotional responses that underlie the interaction patterns within the family system (Johnson, 1996). In addition, the goal is to "modify family relationships in the direction of increased accessibility and responsiveness, thus helping the family to create a secure base for children to grow in and leave from" (p.184). In family therapy, the focus is usually on the identified patient/client and the parents. The identified patient's problems and the inability to prevent adaptation and change is maintained and helped by their relational position in the family. By using new emotional experiences and expression, emotional patterns are modified. It is assumed that if these relationships change for the better, then the identified patient's problem behaviours will also change. This will change how the identified patient is defined in the family and in his/her own inner world.

Intervention/skills

There are numerous key interventions that occur throughout the stages of EFT. These interventions form the basic avenues for accessing emotions, and are integral to the process of change. The interventions that are used to explore and reformulate emotions

include reflections, validation, evocative responding, heightening, empathetic conjecture (Johnson, 1999) and disquisitions (Millikin & Johnson, 2000). In the second stage of therapy, the interventions of restructuring interactions, tracking and reflecting, reframing, and restructuring and shaping are employed.

Reflecting is the process by which the therapist attends to, focuses on, and reflects present key emotions (Johnson, 1996). Through this process the therapist conveys understanding and directs the client's attention to the experience. This involves empathetic absorption of the client's experiences by the therapist and intense concentration. When done correctly, reflections assist the client to feel seen and acknowledged, direct client's attention to their inner experience, and slow down the interpersonal process within the session.

Another key intervention is to *validate* the client's entitlement to their experience and emotional responses (Johnson, 1996). The therapist's role is to validate that there is nothing wrong, irrational, deficient, shameful, or strange with the client's experience and emotional responses. In combination with empathetic reflection, clients are encouraged to become more engaged with their experiences so they can be expanded on and crystallized.

A third intervention is *evocative responding* which is used to capture the quality of the client's experiences that are tentative, unclear, or emerging (Johnson, 1996). The therapist attempts to tentatively expand the client's experience by using evocative imagery. The end result is that the client is able to construct this experience in a more differentiated way. The therapist's role is to guide the clients to the "leading edge of their experience" (p. 46) and invite them to take further steps in formulating and symbolizing

the experience. Questions that may be used during evocative responding are: what happens to you when, how do you feel as you listen to, and what is it like for you. An example would be: what is it about John's tone of voice right now that seems to trigger the sense of the floor dropping away? This question allows the individual to explore and reprocess their experiences.

Another intervention is *heightening.* This may occur during the process of tracking the internal and interpersonal processes (Johnson, 1996). The therapist may choose to heighten specific responses and interactions. The focus is usually on crucial destructive interactions that maintain the client's interactions, however, positive interactions can also be heightened when they occur. Heightening can be used to create novel ways of interacting. Some of the ways that heightening can be accomplished are by repeating a phrase in order to increase its impact, using posture and tone of voice to intensify what is being said, using metaphors and images, enacting responses, and maintaining a specific focus.

With *empathetic conjecture* the therapist uses the client's nonverbal, interactional, and contextual cues to infer the client's current state in order to help the client expand his/her experiences one step further (Johnson, 1996). The aim is to clarify and extend the client's experience so that new meaning can emerge. This intervention does not provide the client with new information about himself or herself; rather the goal is to facilitate a more intense experience. These inferences arise from the therapist's empathic immersion in the client's experiences and his/her knowledge of the interactional patterns and positions of the client.

An example of empathetic conjecture would be the use of disquisitions (Johnson, 1996). These are third-party fantasy narratives, fables or stories about someone other than the client (Millikin & Johnson, 2000). The story is used to reflect and clarify the attachment drama that is implicit in the client's interactions. Disquisitions have specific relevance to the client's stuck points, and they follow the logic and structure of the client's presenting problem and process in therapy. They are always presented as tentative to the clients. Disquisitions are used to legitimize and validate each client's responses through a universal context applicable to all who struggle with close bonds. They can be used when clients become resistant to exploring interactional cycles and underlying feelings. Typically this occurs in steps 3 to 5 in EFT. By incorporating the clients' underlying emotions and interactions positions in the story, the therapist allows for clients to be open to new types of emotional engagements. Clients then can choose which information to incorporate into their interactional patterns.

Through *tracking and reflecting* the therapist focuses in on and clarifies the nature of the relationship (Johnson, 1996). In the early stage of the intervention, the therapist pieces together information from the clients and from direct observation regarding problematic interactions. This information is then reflected back to the clients and identified as a recurring pattern. By identifying and elaborating the negative cycle of interaction throughout the therapy process, the problem is externalized, blame is defused, and destructive arguments aimed at placing responsibility for the problem are decreased. In this process, the destructive cycle is framed as having a life of its own. As therapy goes on, this process is elaborated and differentiated more.

Reframes are placed in terms of the present relationship and arise from the increased elaboration of the emotional reality of the clients (Johnson, 1996). Interactional responses are framed in terms of the attachment process and underlying vulnerabilities. Reframes are most effective when they stem from the client's examination of his/her own experience, how they symbolize the experience, and the process of interaction.

Restructuring interactions within relationships is done through therapist initiated directive choreography (Johnson, 1996). The therapist restructures interactions by directing one individual to respond to the other in a particular way by using encouragement and supporting the expression of needs and wants. Directions may be used to crystallize and enact present positions so they may be expanded on, turn new emotional experience into a novel response that challenges the usual pattern of relating, heighten novel or responses that rarely occur, and choreograph specific change events.

Stages of Therapy

The nine steps to EFT can be divided into three different stages of therapy (Johnson, 1998): Steps 1-4 *stabilisation* (1) assessment, (2) identifying the negative interactional cycle, (3) accessing the unacknowledged emotions underlying interactional positions, (4) reframing the problem. Steps 5-7 are included in the second stage of therapy, *changing interactional positions* 5) promoting identification with disowned needs and aspects of self, (6) promoting acceptance of the client's experience and new interaction patterns, (7) facilitating the expression of needs and wants and creating emotional engagement. Steps 8-9 make up the third stage, *integration and consolidation of positive change* (8) facilitating the emergence of new solutions to old relationship problems, and (9) consolidating new positions and new cycles of attachment behaviour.

These nine steps also parallel the three stages of trauma treatment that have been articulated by McCann and Pearlman (1990): stabilization, building of self and relationship capacities, and integration (cited in Johnson & Williams-Keeler, 1998). The stages and steps outlined may be continuously active and can be experienced by all involved (e.g. therapist, client) in an ongoing, dynamic therapeutic relationship (Johnson & Williams-Keeler, 1998).

Stabilisation (steps 1-4). The first 4 steps of EFT can be viewed as stabilisation (Johnson & Williams-Keeler, 1998) or cycle de-escalation (Johnson, 1998). For trauma victims and their partner, or in this case families, this stage involves understanding the cycles of their relationship, how their ways of coping feed the cycle, understanding the nature of the trauma and how it has impacted on each of the partners (family members) and defined the relationship. Steps 1 and 2 are usually conceptualised as assessment (Johnson, 1996). The goals here are to create a therapeutic alliance with clients, examine the nature of the problem, assess clients' goals, and to create a therapeutic agreement on the goals of therapy. The focus of assessment is on family interactions, the emotional tone of the family, perception of family patterns, and history of family problems. The goals of steps 3 and 4 are to assess the "music of the family's dance" and to use these emotional responses to expand the context of the family's problems. Problems are framed in terms of how the family interacts and the emotional responses that organizes the interactions.

Changing interactional positions (steps 5-7). The second stage involves steps 5 to 7 of EFT and can be viewed as the stage where self and relationship capacities are built (Johnson & Williams-Keeler, 1998), and interactional positions are changed (Johnson,

1998). In this stage, the therapist encourages the clients to produce the relationship as a safe haven (Johnson & Williams-Keeler, 1998). Fears can be confronted in this environment where anger is reprocessed and shame is modified. This stage helps to build trust and a sense of self-efficacy.

Integration and consolidation of positive change (steps 8-9). The last stage (steps 8 and 9) parallels the integration phase of trauma treatment where new positive ways of coping with trauma related problems and new interactional positions are integrated into the relationship (Johnson & Williams-Keeler, 1998). The end goal of therapy is that these new patterns of interactions become self-reinforcing and continue to provide a secure base from which they can continue to cope with the effects of trauma, and develop less stressful perspectives on their relationship problems.

Empirical Research

At this time, there is a lack of research on the impact and success of EFT with families (Johnson, 1996). In the past EFT has focused on couples therapy and only now is research being undertaken in terms of treatment effects for EFT (Johnson, Maddeaux, & Blouin, 1998). Johnson and Greenberg (1985) found that with couples EFT proved to be effective on four outcome measures. The measures used were the Dyadic Adjustment Scale (DAS), Personal Assessment of Intimacy in Relationships (PAIR), Target Complaint Scale (TC), and the Goal Attainment Scale (GAS). Two interesting findings of the study were that treatment effects did not dissipate during the time following treatment, and that EFT can produce significant changes in the quality of marital relationships when novice marital therapists implement it under supervision. This is a key finding with regards to this practicum.

Although the majority of the work with EFT has been applied to couples, there is some research on its application in family therapy, particularly bulimia (Johnson, Maddeaux, & Blouin, 1998). The research examines the use of EFT with adolescents who are bulimic. The results from the study were found to be encouraging, but due to a small sample size, caution was advised. Researchers found that EFT was effective as an established group treatment, and was associated with better rates for binging and vomiting remission than found in previous research. Although the results involved methodological problems, it still serves to show the diversity of EFT and its potential application to family therapy.

In addition to research pertaining specifically to EFT, researchers have also examined the impact of examining emotions in therapy. Diamond and Siqueland (1998) examined the link between core conflictual experiences and primary emotions in cases of adolescent depression. Although they identified that this relationship was unknown, they found that that these emotions and experiences inhibit the depressed adolescent from turning to their parents for support and comfort. By identifying and acknowledging these conflicts, family members were motivated to reach out to each other in novel ways. Furthermore, when core family conflicts were identified and primary emotions were expressed, parents became less defensive, angry, and disillusioned, and more patient, caring, and protective. As a result, adolescents usually responded to the parents by acknowledging their desire for a stronger attachment to their parents.

Evaluation of the EFT model

The founders of EFT, Greenberg and Johnson have been criticized for providing a nine step procedure without revealing the primary focus of their concerns, the issues they

consider more salient than others, how resistance is overcome or collusion averted, and what pattern of moves the therapist could make depending on the problems they are working with (Kahn, 1986). EFT has also been criticized for its lack of biological considerations. Critics argue that it is important to know the source of the act in order to predict the aim and direction of the clients' later-day actions. These proponents call for the inclusion of Object Relations theory within EFT.

The rationale for the use of EFT is that emotions are particularly important in families due to their part in organizing and regulating social interactions within the family system (Johnson, 1998). Additionally, using attachment as a primary therapeutic goal helps to place emphasis on family competency and empowerment, decreases blame and criticism, creates hope and pride, and motivates family members to develop unexplored or forgotten aspects of their relationships (Diamond & Siqueland, 1995; Micucci, 1995; all cited in Diamond & Siqueland, 1998). In adolescence, the presence of at least one reliable parental attachment figure is partially linked to healthy adolescent development (Diamond & Siqueland, 1998).

With particular reference to trauma, Herman (1992) has found that the experience of trauma increases the need for protective/secure attachments (cited in Johnson & Williams-Keeler, 1998). At the same time that the trauma victim strives for attachment, he/she is also ambivalent due to the destruction of trust and security. This is particularly evident when one individual inflicts trauma on another. This constitutes a "violation of human connection" (p. 54).

For these reasons, utilizing EFT is key to uncovering ineffectual family interactions, and thus increasing the functioning of interactions. The incorporation of

emotionally focused strategies within family therapy also serves to address the critique of current family therapies: that they neglect the experiential and the need for clients to experience themselves and their situation differently (Chang, 1993; cited in Johnson, 1996).

Bowen Family Systems Theory

Core Concepts

Bowen family systems theory has been depicted as the most comprehensive view of human behaviour and problems of any approach to family treatment (Nichols & Schwartz, 1998). Murray Bowen is considered one of the founding theorists of transgenerational therapies (Roberto, 1998). As opposed to other theories of family therapy, Bowen Theory delves deeper into the hearts and minds of family members and broadens the scope to include the wider family context that shaped and continues to shape the life of the family (Nichols & Schwartz, 1998). Unresolved emotional reactivity to our parents is carried into every new relationship we enter. From this perspective emotional illness is the result of the cumulative effects of functioning across three or more generations (Griffin & Greene, 1999). Family systems theory assumes that individual differences in functioning and intergenerational trends in functioning are reflective of an orderly and predictable relationship process that connects the functioning of family members across multiple generations (Kerr & Bowen, 1988). The ability to predict the multigenerational emotional process is primarily related to the fact that there exist a finite number of patterns of emotional functioning in nuclear families. The same patterns that exist today are the same that existed many years ago.

Although Bowen theory has evolved and expanded over the years, it has always centered around two counterbalancing life forces: togetherness and individuality (Nichols & Schwartz, 1998). In the ideal situation, these two forces are in balance. Imbalance in the direction of togetherness is termed fusion, stuck-togetherness, or undifferentiation (Kerr & Bowen, 1988). When an individual is differentiated, they have the capacity for autonomous functioning (Nichols & Schwartz, 1998). In other words, differentiation aids the individual in not getting caught up in reactive polarities. If emotional reactivity occurs, then the result is polarized positions, such as pursuer-distancer and overfunctioning-underfunctioning. The terminology used by Bowen theory to express this central tension has changed over time from mother-child symbiosis, to undifferentiated family ego mass, to fusion/differentiation. Regardless of terminology, the central concept is that before one can differentiate a mature, healthy personality, unresolved emotional attachments to one's family must be resolved. This involves active work rather than passively accepting or reactively rejecting one's family situation. The main goal of Bowen Family Systems Theory is to assist each family member to develop a higher level of differentiation of self (Singleton, 1982).

There are seven core concepts which form the core of Bowen family systems theory (Kerr & Bowen, 1988) : differentiation of self, triangles, nuclear family emotional process, family projection process, multigenerational transmission process, sibling position, and emotional cut-off. All seven concepts are "interlocking" and best appreciated when studied together.

One of the main concepts in Bowen theory is *differentiation of self* (Bowen, 1978). This concept is both an intrapsychic and interpersonal concept (Nichols & Schwartz,

1998). Differentiation of self refers to the emotional detachment, or balancing affect and cognition, in order to maintain objectivity (Griffin & Greene, 1999). The differentiated person is able to balance thinking and feeling. Individuals who are differentiated transcend individual and family emotions, use personal principles as a guide, display adaptation and independence in family relationships, and possess a genuine self which is less susceptible to the influence of others, and over time is more consistent in decisions. They are able to express strong emotions and spontaneity, but also capable of objectivity and restraint in order to resist the pull of emotional impulses. Although well-differentiated families usually have no symptoms, they can develop under sufficient stress.

Undifferentiated families are rarely without symptoms (Kerr & Bowen, 1988). With the addition of stress and anxiety, the families' chronic symptoms worsen and new symptoms usually appear. People who are undifferentiated have a very difficult time balancing their thoughts from their feelings, because their intellects are so flooded with feelings that they are almost incapable of objective thinking (Griffin & Greene, 1999).

A second concept is *triangulation* which is the result of subsystems that are unstable (Griffin & Greene, 1999). Stressed dyads seek relief by incorporating a third party into their interactions. Triangulation that involves a child can result in emotional illness that persists into adulthood. The concept of emotions is central to triangulation and represents one of the primary emotional units in the family (Dallos & Draper, 2000). Triangulation is particularly important in families with adolescents due to the strong demands of the adolescent, which can serve as a catalyst for reactivating emotional issues and set triangles into motion (Preto, 1999). In adolescents, triangles generally involve the

following individuals: the adolescent, the father, and the mother; the adolescent, a parent, and a grandparent; the adolescent, a parent, and a sibling; or the adolescent, a parent, and the adolescent's friends.

Nuclear family emotional processes refer to the four relationship strategies used by spouses to handle anxiety (Griffin & Greene, 1999). These are:

1. Emotional distance - ignore or avoid one another in order to avoid discussions of conflictual matters.
2. Marital conflict - creation and maintenance of extremely intense arguments.
3. Spousal dysfunction – taking complementary roles as overfunctioner and underfunctioner.
4. Child dysfunction – triangulating a child into the interaction resulting in symptom manifestation in the offspring.

Emotional cut-off refers to the extreme forms of distancing between individuals in emotionally fused families (Griffin & Greene, 1999). Individuals who are undifferentiated withdraw both physically and emotionally in order to cope with the anxiety that is present in the defective system. The disadvantages of this include a decrease in the available supports in the nuclear family and replication across generations. Kerr and Bowen (1988) do not see cut-off as inherently good or bad because of its ability to reduce anxiety. It can serve as a coping mechanism to reduce psychological anxiety. However, from a Bowenian perspective cut-offs are also viewed as signs of extreme reactivity and are used to indicate low differentiation of self.

Cut-offs do not necessarily reduce anxiety, but may in fact increase anxiety. Individuals may feel it is easier not to deal with people and situations which are difficult,

but by not addressing them the individual loses the emotional connections that have the potential to be stabilizing (Kerr and Bowen, 1988). The more complete the cut-off from the past, the more likely that a more intense version of the past will be repeated in the present.

By gaining more emotional objectivity with one's family of origin, and as contact with family occurs rather than being cut off, then the amount of anxiety and emotional distance in the relationships with spouse, children, and important others will decrease. This is because "seeing oneself as a part of the system in one's original family enhances one's ability to see oneself as part of the system in one's nuclear family" (Kerr & Bowen, 1988, p. 273). During adolescence, unresolved conflicts between parents and grandparents have the potential to resurface (Preto, 1999).

Family projection process refers to how parents transmit their immaturity and lack of differentiation to their offspring (Nichols & Schwartz, 1998). This emotional fusion results in anxiety between the spouses, and potential triangulation of a child (Griffin & Greene, 1999). The degree of family projection is related to the level of immaturity or undifferentiation of the parents and the level of stress or anxiety in the family (Levant, 1984).

Multigenerational transmission process refers to the pattern that emerges over the generations as various levels of immaturity are transmitted from parents to children (Bowen, 1978). Within any generation of a family there will be an average level of differentiation (Levant, 1984). One member of the generation will experience a lower level of differentiation. This will be reflected in a greater degree of unresolved attachment to the parents. This individual will marry someone with the same level of

differentiation and they will have a certain degree of fusion to disperse in their family. One child will be more triangulated than others and this will result in a lower level of differentiation than the parents.

The concept of *sibling position* is based on Toman's work (1976, cited in Levant, 1984). Based on sibling position certain personality profiles were developed. The degree to which the child is similar to Toman's personality profile can be an indication of their level of differentiation and the degree of triangulation within the nuclear family unit.

Therapeutic goals

The main goal of Bowen theory is to help clients uncover the multigenerational family dynamics that cause emotional illness, to develop strategies to become less reactive and more objective, and to foster change in the nuclear and extended family system (Griffin & Greene, 1999). By working with the individual, the therapist hopes to extend individual improvements to the nuclear and extended family system. In regards to the individual, the goal is to make sure that one type of functioning does not dominate over the other. For example, emotions should not dominate over thinking, rather, that individuals have more than one way to respond.

Techniques

Bowen theory did not emphasize the use of specific techniques, however, the use of genograms and I-positions are frequently used (Nichols & Schwartz, 1998). The data gathered by doing a genogram is used to understand the underlying multigenerational emotional process of the family (Kerr & Bowen, 1988). Family genograms can also be used to explore family attachments, as well as many other emotional aspects of family interaction (e.g. anger, sadness) (Dallos & Draper, 2000; DeMaria, Weeks, & Hof, 1999).

The process of making a genogram usually occurs by exploring one family of origin at a time (Brock & Barnard, 1999). A great deal of information can be gathered; dates of marriages, deaths, divorces, births, and ages of family members. The nature of the relationships making up the structure of the genogram is the most important information and is secondary to the family structure. One outcome of doing a genogram as an initial task of therapy is that it provides an opportunity for the therapist to demonstrate professional competence.

Bowenians also use I-positions that are requests or statements that emphasize the individual's personal responsibility for attitudes, behaviour, or affect (Griffin & Greene, 1999). I-positions enhance objectivity, because the speaker refrains from blaming. Taking a personal stance and saying what you feel, instead of what others are "doing" is one of the most powerful ways to break cycles of emotional reactivity (Nichols & Schwartz, 1998). Another benefit of using I-positions is that it decreases confrontation by displacing the focus, making it less personal and less threatening. This is a particularly important technique which helps to decrease the emotional reactivity that occurs within family interactions.

Evaluation of Bowen Family Systems theory

Early research on the application of Bowen theory involved schizophrenic families and was more clinical observation than controlled experimentation (Nichols & Schwartz, 1998). Bowen preferred to refine and integrate theory and practice rather than collect empirical research. Although Bowen's theory was consistent and thorough, it was largely constructed on clinical observations. The tenants of the theory were not supported by empirical research and were most likely not amenable to confirmation or disconfirmation

in controlled experimentation. The theory was probably "best judged not as true or false, but as useful or not useful" (Nichols & Schwartz, 1998, p. 171).

Personal experience and clinical reports were used as evidence for the effectiveness of family of origin work (Nichols & Schwartz, 1998). Compared with others, Bowen therapists did at least as well as the standard figures; one-third of the clients got worse or no better; one-third of the clients got somewhat better; and one-third got significantly better.

A study by Hurst and Sawatzky (1996) uncovered a high frequency of multigenerational problems that were consistent with Bowen's theory. The study examined family processes in 17 multi-problem families through a Bowenian lens. Based on Bowen's theory, it was hypothesized that the parents in these families would exhibit lower levels of differentiation when compared to a norm group of adults drawn from the general population. Additionally, it was predicted that these families would manifest specific patterns of multigenerational problems. Findings were consistent with the initial hypotheses and Bowen theory. The authors concluded that Bowen theory is useful with clinical practitioners who work with multi-problem families.

Integration of Theories

Similarities

Both theories allow for the family to be seen together at least during initial sessions. The rationale for this is similar in both theories. In EFT, conjoint family sessions are used to assess interactional positions and patterns, and to identify problematic relations and family cycles that may be related to the symptomatology in the

identified patient (Johnson, 1996). Both theories agree that individuals do not operate in isolation and parts must be understood only in the context of other family members.

The techniques used by EFT and Bowen theory are both very empowering and serve to enlighten the family to consider new ways of viewing the situation. Taken as a package the knowledge generated through developing different types of genograms (e.g. attachment, anger) can aid in the exploration of emotions and, particularly, uncover primary emotions.

One of the interventions used in EFT, namely tracking and reflecting is focused on identifying problematic interactions and reflecting these patterns back to the clients in terms of a recurring pattern (Johnson, 1996). The recurring patterns that are most common are blame/defend or pursue/withdraw. This intervention works very well with Bowen's concept of differentiation and the interactional dances in which individuals partake. Family members often are stuck in patterns that are problematic and leave no room for change. By tracking these patterns and reflecting them back to the clients, these interactions can be shared with the family and modified to engage in more productive interactional patterns. By uncovering these patterns powerful change can occur in the family unit that can assist the process of differentiation from one's family of origin. This example helps to illuminate the overlap and benefit of EFT interventions when combined with the theoretical concepts of Bowen family systems theory.

Elements related to attachment may be addressed in the assessment period of Bowen family systems theory. By using attachment genograms, patterns of attachment stemming from one's family of origin can be explored. Attachment relationships with primary caregiver(s), sibling(s), and extended family members can offer useful

information regarding family of origin issues. Attachment genograms may also serve to identify individuals who provide support and comfort to the family.

Both theories pay tribute to the importance of secure attachments and the impact on family interactions. In Bowen theory, "the degree of unresolved emotional attachment is equivalent to the degree of undifferentiation" (Bowen, 1978, p. 534). In Bowen theory, a securely attached individual is one who is differentiated. Individuals are not differentiated or undifferentiated, rather, there is a continuum of with no final level of differentiation. The greater the degree of unresolved emotional attachment to parents and the lower the level of differentiation, the more intense the mechanisms to deal with the undifferentiation, and vice versa. One cannot be securely attached and be undifferentiated; both concepts require the inclusion of the other. In this respect there is a link between the two concepts that are key to EFT and Bowen theory.

Differences

Although family of origin issues arise in both EFT and Bowen family systems theory, the extent of the analysis and the reasons for examination differ (Johnson, 1996). For example, EFT only examines family of origin issues as they play out in the therapy room (Johnson, 1996). On the other hand, Bowen theory actively works to uncover unresolved family of origin issues as they operate in the present. In this respect, EFT can be seen as more present orientated than Bowen theory that focuses more on multigenerational historical patterns.

In addition to differences in the attention paid to emotions and family of origin, the two theories also differ in their attention to theory. Bowen theory is very theoretical - the articulation of concepts has been explored in great depth (Nichols & Schwartz, 1998).

The theoretical underpinnings of EFT are not well explicated beyond its incorporation of attachment theory; rather EFT relies on well-outlined steps and interventions. Murray Bowen believed in theory over technique and that it is important not to become preoccupied with specific techniques (Nichols & Schwartz, 1998). In this respect, the two theories are well suited to work together, the lack of attention to theory in EFT, and the lack of attention to techniques in Bowen theory work together to form a comprehensive approach to family therapy.

Bowen family systems theory and EFT see change occurring in two different ways. The process of change in Bowen Family Systems Theory is that by increasing the basic level of differentiation in the symptomatic person or someone closely connected to him, symptoms can be reduced (Kerr & Bowen, 1988). The two basic principles that govern this change are that a reduction of anxiety will relieve symptoms, and an increase in the basic level of differentiation will improve adaptiveness. Self-differentiation improves as the marital dyad stabilizes through the regulation of the amount of interaction between the dyad and through the focus on cognitive over affective functioning.

In EFT, the process of change involves three discernible shifts: cycle de-escalation, withdrawer engagement, and blamer softening (Johnson, 1998). The first shift is a first order change. In other words, the way interactions are organized remains the same, however, the elements of the cycle are somewhat modified. The other two shifts involve second order change, such that they constitute a change in the structure of the relationship. In the second shift, withdrawer engagement, the withdrawn partner becomes more active and engaged in the relationship. As a result, the interactional positions change in regards to control and accessibility for contact.

On closer examination of the process of change we can see some underlying similarities. For example, Bowen theory sees the first change process as the reduction of anxiety and EFT outlines cycle de-escalation. Both processes serve to stabilize the client system in order to re-structure the interactions.

CHAPTER 4: INTERVENTION

Learning Goals

One of the major learning goals of this practicum centred around increasing both my theoretical and practical knowledge of Bowen Family Systems Theory and EFT. As a practitioner it is important to have a thorough understanding of both theory and techniques which can be incorporated into the intervention. In addition to having knowledge of both theories independent of each other, it is also important to know how each theory has similarities and differences. Through this process we are able to apply an integrated approach to family therapy which acknowledges the limitations and strengths of each theory.

A second learning goal was to develop and practice skills to work with and consult within a multidisciplinary setting. It is important for social workers to acknowledge the knowledge generated from different disciplines. It can be very helpful to consult with individuals whose knowledge base differs from our own. Through this process we are able to develop a more comprehensive look at the problem and subsequently, a more effective intervention.

The third learning goal involved increasing my knowledge and practical skills when working with families who present with multiple problems and diverse backgrounds (e.g. culturally, economically). Clients come with a variety of backgrounds which may play a enormous role in how they function as a family. Family rituals, morals and values have to be considered within the cultural system from which they originated. In order to provide effective, helpful, and most importantly ethically appropriate

interventions, we must increase our knowledge of different cultures, economic situations, and family structures.

A fourth goal was to develop confidence in being the primary therapist and to develop the skills to distinguish between content and process in family evaluation. Understanding process can be very helpful during the assessment and treatment. As theoretical and practical skills are applied to the therapeutic domain, it is possible that confidence will increase.

Setting

The practicum took place in the Psychological Trauma Clinic which is part of the Child and Adolescent Mental Health Program at St. Boniface Hospital. The building provided multiple locations for family therapy, and access to both video recording and audio taping equipment.

Clients

Clients were recruited from the Psychological Trauma Clinic and the Family Therapy Clinic. Prior to the selection of clients for the practicum, a central hospital intake process determined the therapeutic needs of clients. Once the client had been initially assessed, the client was referred to a specific hospital department. After referral to the Psychological Trauma Clinic or Family Therapy department, another more in-depth assessment occurred. Once this was completed, I then reviewed the case and determined suitability for inclusion in the practicum.

Criteria for inclusion in the practicum were that the client (12-19 years of age) had experienced a traumatic event or loss which effected his/her ability to cope with life

events and/or families coping with the adolescent transition. Additionally, the identified patient and their family attended family therapy on a voluntary basis.

Although all family members were included from the onset of therapy, individual, dyadic, and triadic counselling were also applied. Preto (1999) has stated that working with subsystems individually increases the therapist's ability to manoeuvre between supporting both generations at the same time. A second advantage is that the therapist is able to avoid getting caught in power struggles.

Prior to the start of therapy, all clients were asked to read over and complete a consent form (Appendix A). This form contained information which outlined the purpose of the practicum as a requirement for the completion of a Masters in Social Work Degree and a final report on my learning experience. Additionally, there was information on the practicum procedures which outlined what is provided, by whom, and what was required by the participants. Confidentiality, voluntary participation, and direction regarding questions and complaints were also discussed. Participants were told that information gathered might be published, but with no identifying information included.

Within the first session, clients were asked to fill out the General Scale of the FAM-III (Skinner, Steinhauser, & Santa-Barbara, 1995). This questionnaire is designed to access information on basic family functioning and was used for both assessment and evaluation purposes. At the end of the intervention family members were asked once again to fill out the questionnaire.

In addition to direct work with clients, I also participated in observing family therapy sessions and participated in reflections with various professional therapists (e.g. social workers). I found the reflecting approach as a very useful way to uncover the

process and content of various families presenting with different problems. The opportunity to view different therapists in action also helped to solidify and conceptualise the different ways of intervening with families.

Intervention

In order to fulfill the requirements for the practicum six families were seen for a minimum of five sessions. Family interventions involved a combination of conjoint, individual, dyadic, and triadic family therapy. EFT and Bowen Family Systems Theory were incorporated and integrated into the family therapy assessment/intervention. The decision to use both these approaches derived from consultation with my advisor Brenda Bacon and clinical supervisor John Smyth, a review of the literature, and preliminary exposure to the client population. The primary theoretical approach was EFT, however, elements of Bowen family systems theory, the secondary focus were interwoven.

Since the clientele involved adolescents 12-19 years of age it seemed appropriate to involve all family members in the intervention process. Kerr and Bowen (1988) have stated that the functioning of one person cannot be adequately understood without examining the functioning of the individuals closely involved with him. Second, as Murray Bowen found through his experience working with families, no matter where we go, our family remains with us (Nichols & Schwartz, 1998). Family issues must be rectified and resolved before an individual can move on in new relationships. A third rationale for the use of Bowen theory is that it takes the focus off the identified patient and places it within the context of the family. We cannot ignore the impact that the family has on the identified patient. Without attending to family interactions and family of origin issues, it is likely these patterns will continue with future generations.

An eclectic approach to family therapy acknowledged the strengths of each approach and integrated them in a way that was most beneficial to the client population. EFT was chosen because of its link between trauma and emotions, well outlined steps and techniques, and my curiosity to extend EFT into work with families. Bowen theory picked up on the important element of family of origin, outlined specific techniques (e.g. genograms), and had a strong theoretical base which built on the weaknesses of EFT.

The nine steps of EFT provided the foundation for therapy sessions with additional concepts and techniques related to Bowen theory intertwined. In the beginning of therapy there was a larger focus on family of origin as outlined by Bowen theory. This helped to provide a basic understanding of the family dynamics, key nodal events, and to aid in the process of joining and engaging families. Throughout the intervention there was sometimes a return to family of origin issues as they were played out in the therapy sessions. In addition to the nine guiding steps of EFT, the intervention also formalised family specific session goals, however, sessions also followed the tone of the family and were flexible and respectful in order to incorporate the families' changing needs.

Evaluation of Learning Goals

Supervision

My committee was comprised of my advisor Brenda Bacon, clinical supervisor John Smyth, and committee member Barry Trute. Consultations with the committee occurred twice over the course of the practicum (i.e. proposal phase and report phase). John Smyth supervised family intervention sessions on-site. On-going and frequent consultation occurred with Brenda Bacon.

Summary recording

After each session, a summary recording was completed (Appendix B). The summary recording had the advantage of being less time-consuming, more selective, and more focused than process recording (Toseland & Rivas, 1998). One of the main reasons for collecting this data was to keep the practitioner abreast of family development and family progress.

Elements collected by the summary recording sheet related to general session statistics (e.g. session number, date, who was present), skills taught, discussion topics, questions raised, practitioner concerns, and potential areas of discussion for next session. Reliability of the practitioner log was verified by videotaping (when equipment available) each session. Additionally, the logs were used to plan for future sessions and for consultation with committee members. I personally used the logs as a reflective process in order to examine my intervention progress and to analyze and critique my strengths and weaknesses.

Video recording

In addition to practitioner logs, sessions were videotaped when equipment was available, and clients consented to its use. Ideally, family therapy took place in rooms equipped with a video recording device. This documentation was used to reflect on practitioner skills and application of the theoretical approaches. Videotaping also served to assess my level of differentiation from the family (Griffin & Greene, 1999) which was very important to examine when using Bowen Family Systems Theory. Videotapes were viewed in private and were stored in a secure location.

Family Assessment Measure (FAM-III)

The General Scale of the Family Assessment Measure Version III (FAM-III) was used pre and post intervention. The FAM-III is a self-report instrument that provides quantitative values of family strengths and weaknesses (Skinner, Steinhauser, & Santa-Barbara, 1995). The FAM-III General Scale consists of 50 questions which can be subdivided into seven basic concepts: *Task Accomplishment, Role Performance, Communication, Affective Expression, Involvement, Control,* and *Values and Norms.* Built into the measure are two subscales which indicate distortions of the responses (i.e. *Social Desirability* and *Defensiveness*).

All family members were asked to complete the questionnaire in the first and last sessions. All respondents were given the following instructions: it will take approximately 10 to 15 minutes to complete, answer all questions and there are no right or wrong answers.

Post-intervention questionnaire

During the last session, clients filled out a questionnaire regarding their experience in therapy (Appendix C). The questions addressed what was perceived as most helpful to the client. The questions were brief and only took 10-15 minutes to complete. This information was used to reflect on my role as a therapist and to incorporate the clients' viewpoints into my learning experience.

Required hospital documentation

In addition to evaluation methods which pertain to this practicum, the completion of required hospital documentation was also provided (e.g. Hospital statistics, progress notes). This was an important aspect of the practicum as it added to my learning

experience within a multi-disciplinary unit, and furthered my knowledge of hospital procedures.

CHAPTER 5: THE PRACTICUM

Overview of Families

During the time I spent at the Child and Adolescent Mental Health Program at St. Boniface Hospital, I worked with six families. Families came from both the Psychological Trauma Clinic and Family Therapy Clinic waiting lists. Prior to the first contact with any of the families, I reviewed the referral in order to get an overview of who was in the family and what the presenting problem appeared to be at the time of referral. The first contact with the family was done by telephone and included an overview of my role, supervision, videotaping, and completion of the FAM-III. Additionally I asked for a general idea of what the family's presenting or most prevalent issues were.

Table 1 outlines some of the background information on five of the families seen during this practicum. This includes information on family structure, number of children/adolescents, previous exposure to family therapy, presenting problem, use of Bowen Family Systems Theory, use of EFT, number of sessions, and exposure to psychological trauma and/or separations.

One of the five families was a single parent family, three out of the five families were two parent families, and in one family, the adolescents lived with a foster family. Two families had fathers whose jobs involved long periods of time away from home (e.g. long-haul trucker). In one family, there was an only child, while the majority had at least one other sibling.

Half of the families had prior experience with family therapy. Some of the information regarding prior exposure to family therapy came from hospital charts, while

other information came from the families themselves. This provided me with some background information on what was and was not helpful for these families. In all families, the prior experience was brief, usually only 2-5 sessions. In the case of the Gordon family, background information was used to rationalize using an approach that differed from previous therapy.

In addition to seeing the writer for family therapy, three of the adolescents who were the "identified patient" were also seeing someone individually. Furthermore, all of the adolescents or parents had exposure to individual therapy either in the present or past.

All of the presenting problems included some component of parent-child conflict. Additionally, families faced other problems including anxiety, attachment problems, psychological trauma, loss, sibling conflict and marital conflict.

All of the families had experience with separations, psychological trauma, and/or loss in the past or currently. Separations from primary caregivers had occurred in 2 of the 5 families. In one of the families, the separation was within the first 10 years of life. The other family had experienced the separation during late childhood (i.e. 8-10 years of age) and in early adolescence.

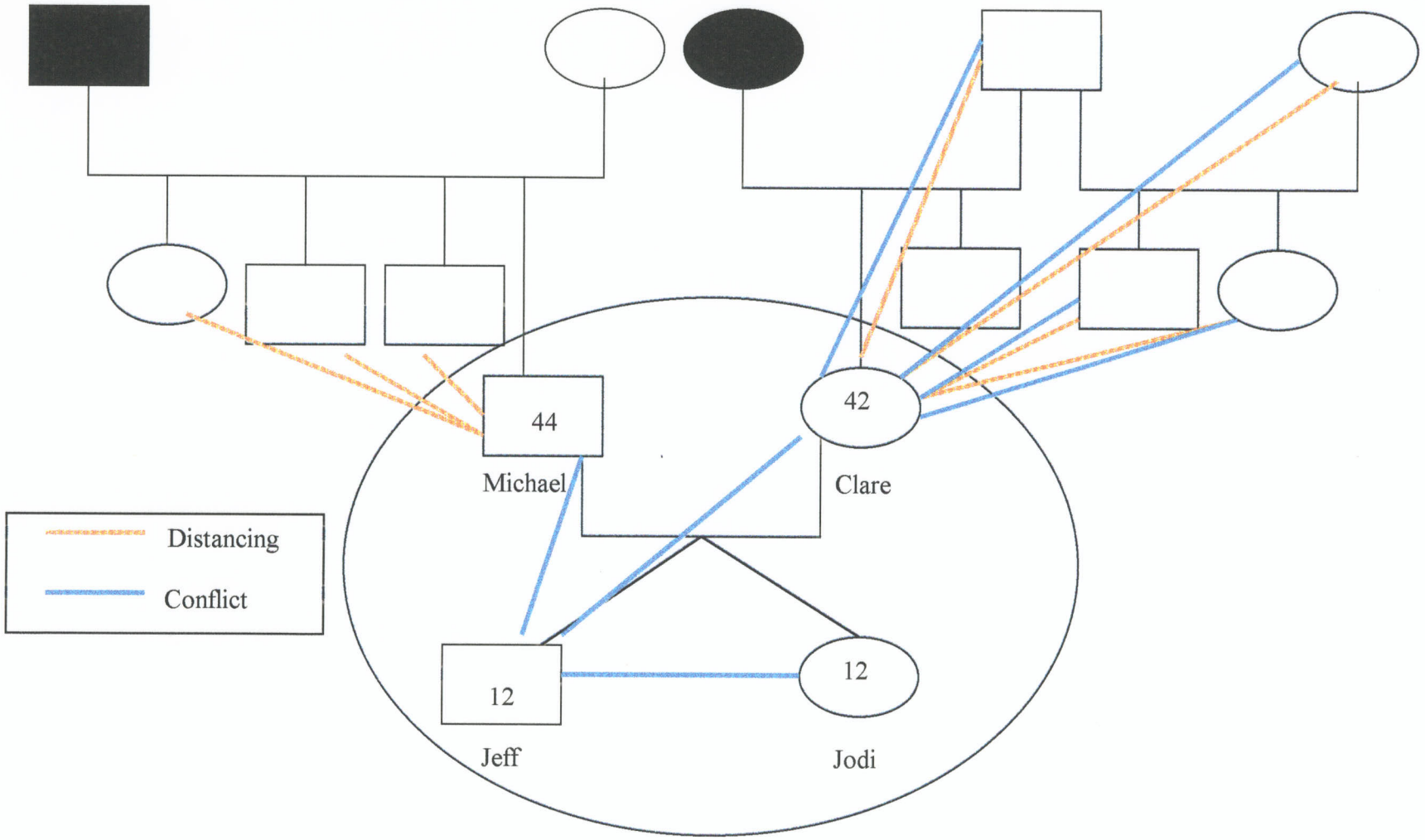
The degree to which Bowen Family Systems Theory was used in the intervention varied from family to family. In 3 out of 5 families, an in-depth genogram was gathered to facilitate the assessment process. In these cases the genogram helped to assess information regarding multi-generational processes and possible focuses for intervention. EFT was used with all five of the families. However, the degree to which it was applied, techniques used, and the parallel to the 9 steps of EFT varied for each family. Some of the families responded better to EFT than other families.

Three families will be briefly discussed in terms of assessment, hypothesis, goals and objectives, interventions, and outcome and evaluation. For these families, I have chosen to discuss a few key areas that added immensely to my learning experience. Additionally, two families will be discussed in greater detail and analyzed in this chapter. These two cases were selected because they most closely represent the use of Bowen Family Systems Theory and EFT. Both cases were unique and provided a different perspective on the use and appropriateness of these interventions.

Table 1: Overview of Families

Family	1 Davidson	2 Anderson	3 Richard	4 Lodge	5 Gordon
# of Sessions	11	5	11	11	11
Family Form	Two parent	Two parent	Two parent	Foster Care	Single parent
Presenting Problem	- Parent-child conflict - Sibling conflict	Parent-child Conflict	-Grief -Marital Conflict -Parent-child conflict	Insecure attachment	- Anxiety - Problems with differentiation - enmeshment
Prior Family Therapy	Yes	Yes	No	No	Yes
Number of Children at home	2	1(2 not living at home)	2	2 (in foster care)	1
Separation/ loss/or trauma	Yes	Yes	Yes	Yes	Yes
Emotion Focused Therapy	Yes	Yes	Yes	Yes	Yes
Bowen Family Systems Theory	Yes	Partial family history	Partial family history	Yes	Partial family history
Other theories/ Approaches used	- Structural Theory	- Structural Theory	- Grief Work - Narrative	- Structural Theory	- Structural Theory - Narrative

Figure 1: Family #1 Genogram



Brief Exploration of Case Studies

Family 1: The Davidson's

The Davidson family consisted of 12-year-old fraternal twins (Jeff and Jodi), a 44-year-old father (Mike), and a 42-year-old mother (Clare) (Figure 1). Jeff was the identified patient. He presented with Attention Deficit/Hyperactivity Disorder and anger management problems. Jeff frequently acted out at home and school and was jealous of his sister's accomplishments. He was being seen for individual and group therapy for some of these problems. Additional family issues included financial stress and Mike's major mental illness. Despite being diagnosed with a major mental illness, Mike was able to work full-time. Clare was not employed outside of the home, however she had recently started exploring the possibility of outside work. Mike's role was to financially support the family, while Clare was responsible for parenting the twins. The presenting problem was parent-child conflict and sibling conflict.

Assessment

From a Bowen standpoint, emotional and physical distancing from both Mike's and Clare's family of origin was a common theme. Although both individuals had contact with their families, they were not seen as a source of support. There were unresolved issues on both sides that strained these relationships. The literature states that emotional intensity in the marital relationship can be toned down if one or both partners maintain sufficient emotional attachment to their parents (Bowen, 1978). Neither Mike nor Clare remained connected to their parent(s). Clare's mother passed away when Clare was five, and her brother was three. Her father remarried shortly after and had two other children. Her relationship with her stepmother was less than ideal, and left Clare feeling hurt and

separated from her father. In recent years, the Davidson's had adopted distance in order to decrease contact with Clare's side of the family.

Mike also distanced himself from his mother and siblings. He had a cordial relationship with his mother, but a theme of secrecy seemed to permeate the relationship. Details related to his father's death were kept from Mike, in order to decrease Mike's stress and worries. This resulted in Mike feeling "in the dark" and angry regarding family issues which were kept in secrecy. The family adopted the same distancing patterns with Mike's family of origin. As a result there were few individuals outside the immediate family involved in providing support.

A second concept that was particularly important for this family was differentiation of self. From Bowen's (1978) extensive study of families with a schizophrenic offspring he found that individuals who develop schizophrenia never achieve differentiation from their family of origin and always function as "dependent appendages of the family ego mass" (p. 110). Some individuals achieve a "pseudo-self" to function independently for brief periods, but long-term separation from the parental ego mass is possible only when another ego mass to attach to is available. In this family, Clare functioned as the ego mass that Mike could attach to for guidance and advice, and from whom he could borrow enough self to function. This dependent attachment may maintain equilibrium throughout the life span, but it is extremely vulnerable to any threat and can collapse into psychosis with the presence of life events that threaten or disrupt this dependant attachment.

A third area of assessment was the lack of support in the parental sub-system. Issues relating to Mike's job schedule and his mental illness and the families pattern of excluding the father kept him isolated and alienated from family problems. As a result,

the majority of the parental responsibility was left to Clare. This was a major source of stress for Clare. From the perspective of Structural Theory, the executive system in the family Clare was unsupported. This resulted in a weak executive system that frequently became overwhelmed by parent-child conflict. Clare was responsible for disciplining the children, but was unable to enforce punishments when Jeff's behaviour was out of control. This became more problematic when Mike was at home and distanced himself from conflict situations. Clare experienced the lack of support as a frustration and this frequently resulted in marital conflict.

Assessing the family from an EFT perspective brought to light the many ways that emotions were regulated in the family. Jeff had a very difficult time regulating his emotions. He would frequently get angry. This anger would quickly escalate to the point where Clare had to restrain him. In terms of his ability to regulate his anger, Jeff's diagnosis of ADHD played a role. However, Jeff also experienced a lack of emotional connection to his father. It was hypothesised that when Mike was home Jeff's anger would escalate because of Mike's distancing from the situation. Furthermore, when Mike did not leave the situation he had difficulty controlling his anger which resulted in increased conflict. In this way Jeff was replicating his father's emotional pattern. Both Clare and Jodi had the capacity to regulate their emotions, however, with some emotions there was over-regulation. For example, when discussing family of origin, Clare worked extremely hard to regulate her sadness and frustration regarding the situation. This also occurred when discussing the difficulties with Jeff. Clare's over regulation of emotion may have been a protective device, however, it also seemed to mimic unresolved emotions regarding her family of origin.

In addition to the regulation of emotions, Mike's distancing from the family was also identified as a problem. In times of conflict, Mike would distance himself from the family by physically leaving the environment. This was part of his strategy to relieve stress and maintain control over his mental illness. Clare experienced his distancing as a source of frustration and an abandonment of their parental responsibilities. Mike's pattern of distancing left Clare alone to deal with conflict situations with Jeff.

Treatment Goals and Objectives

1. To increase the boundary around the parental sub-system in order to strengthen the executive system.
2. To increase communication within the parental sub-system.
3. To decrease sibling rivalry.
4. Access and uncover key emotional responses that underlie the interaction patterns within the family system in order to strengthen the attachment bonds between family members.

Intervention

This family provided a challenge in terms of suitability of EFT Interventions. The identified patient presented with an under-regulation of emotion, and the father had been diagnosed with a major mental illness. I was very cautious and consulted with other therapists; as well did some research on the implications of using a family intervention that elicits strong emotions. Determining the appropriateness of an intervention involves a variety of components. This may include the family's history of therapy, history of illness, client's own responses, and the clinician's intuition. When I explored the family's history of previous experience with other therapists, I found that they had explored

emotion, and that other therapists had felt this was not contraindicated. Additionally, the father's major mental illness had been stable for the past 4 years. He was in regular contact with his doctor, and the family was aware of any signs associated with a relapse. A component built into each therapy session was to ask safety questions, such as "how do you feel after the session". This was important in order to access information on the client's safety and allow the family to voice any concerns.

Mike and Clare did agree that family of origin issues were a strain on them, however, due to the presence of family issues in the immediate family, extended family issues were not a priority. I discussed with the couple how communication and support was important to maintain a strong executive system. By using EFT we explored emotions related to Clare's frustration over not being supported and Mike's difficulty in maintaining his composure in conflict situations. This intervention was related to Goals #1, #2, and #4. Distancing in the marital relationship was explored by uncovering emotions that were previously hidden. EFT techniques, such as reflections, validation, and heightening were used to forward the couple's experiences. Heightening was used to bring to light the negative interaction of distancing. This was highlighted due to its part in keeping the couple isolated and unsupported. After distancing was highlighted, empathetic conjecture was used to focus in on how the distancing made them feel. This helped to bring the client to the "leading edge of their experience" (Johnson, 1996, p. 46).

After several sessions involving the couple only, Clare requested that the focus change to sibling rivalry. With this surprising change, I spent time after the session exploring what may have resulted in the shifting focus. A couple of reasons for the switch from couple to sibling work came to light. Mike was experiencing stress and had to

increase his medication. This may have been a reality check for Clare in terms of Mike's level of tolerance and ability to manage more responsibility in the home. A more probable explanation for the shift was the increasing sibling conflict in the home. I struggled with the change in focus and wondered whether to follow the client's requests. In the end I decided to allow the change in focus in order to maintain a strong therapeutic alliance and address more pressing family issues.

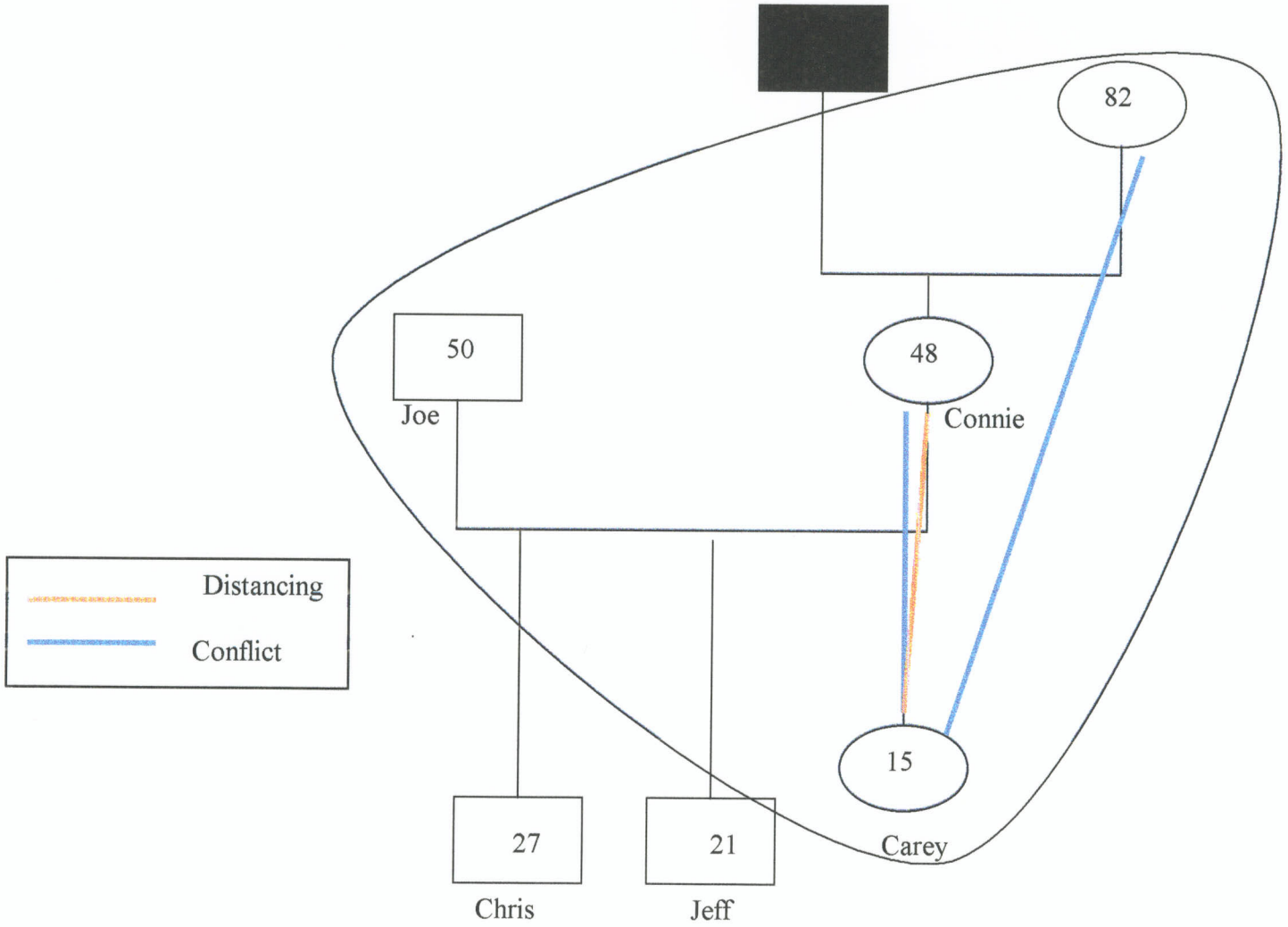
One of the interventions used to decrease sibling rivalry (Goal #3) was to meet separately with the sibling sub-system. The rationale was to enhance sibling attachment in order to decrease sibling conflict and parental stress. Clare was concerned over the level of jealousy Jeff had towards Jodi. This caused frequent outbursts between the twins and compounded Clare's stress level. Meeting four times with Jeff and Jodi, we focused on what it was like to be a twin and to explore interests that were common to each. Drawings were used to allow the twins a medium to share their experiences. I had the twins draw two pictures, one of their family in the present, and one of their family in the future. The theme of Jeff's picture surrounded his belief that all of the family problems were his fault. His picture of the future displayed a lack of hope that the situation would get any better. He believed that he would be incarcerated in the future. When asked to draw another scenario for the future, he still indicated his belief that the future was not going to be better. Jodi's pictures were more optimistic and were used to show Jeff that there were other views of the future. Furthermore, Jodi's picture displayed other stresses for the family, including their dad's mental illness. This highlighted for Jeff that there were problematic issues other than his behaviour.

In the last half of each session we played games that were incorporated into the theme of the session. For example, in the first session the focus was on getting to know each other. During our game, we made additional rules which focused on sharing information about likes and dislikes. This strategy provided a very simplistic and fun way to build the therapeutic alliance, and allowed Jodi and Jeff an opportunity to learn more about each other and increase the sibling bond.

Outcome

One of the problems associated with being one piece of a multi-system intervention was that it is difficult to determine what influence one intervention had over another. The family was involved in three interventions, family, individual (Jeff, Mike), and group therapy (Jeff). All approaches worked to form a supportive network for the family. In terms of original therapy goals, changes were seen in communication patterns in the parental and sibling subsystems. At the end of therapy all family members reported increased communication. Therapy also served to increase the support network for Mike and Clare. It provided an opportunity for the parental subsystem to express their feelings and emotions. This was a relatively new experience for the family and allowed the surfacing and venting of some frustrations. Lastly, therapy helped to strengthen the boundaries between parental and child subsystems. The parents and children were separated during portions of the therapy in order to develop the opportunity for age and role appropriate interventions. Issues relating to parenting were solely discussed in couple sessions, while sibling rivalry was addressed in sibling sessions.

Figure 2: Family #2 Genogram



Family 2: The Andersons

The Anderson family consisted of a 15-year-old female (Carey), a 48-year-old mother (Connie), a 50-year-old father (Joe), 27 and 21-year-old males (Chris and Jeff), and an 80-year-old maternal grandmother (Figure 2). Chris and Jeff lived separately from the family. Carey's father was home only seven days a month and was not a major part of parenting. In addition to Carey attending family therapy, she had attended individual therapy for the past two years. Carey had experienced difficulties stemming from a break-up with a former boyfriend. Mother was also seeing someone individually for depression and was currently on medication. The initial referral was for family therapy in order to deal with parent-child conflict. The onset of the problems seemed to correlate with the entrance into adolescence.

Assessment

It quickly became apparent that Structural Theory would provide a good base for exploring this family system. The mother had a very weak executive function in the home. This seemed to be affected by a lack of support by her husband. Connie had difficulty maintaining any rules and quickly gave into Carey's requests. This was a major stress for Connie as she felt that Carey gave a good argument for what she wanted; therefore, she always gave her what she requested. In addition, Connie frequently felt stupid when arguing with Carey which impacted on her self-esteem.

Sibling position and gender also seemed to play a factor in this family. Carey was the youngest child separated by six years to her nearest sibling. Furthermore, she was the only daughter. Connie was experiencing difficulties with her daughters accelerated wish to transition into the family life cycle stage of "leaving home". Connie's whole self was

wrapped up in her role as caregiver. She had raised two sons and a daughter and was the primary caregiver of her mother. She did not work outside of home and spent most of her time providing care to others. Carey felt her mother was "holding on too tight", and if she started to separate now it would not be as painful for her mother. When Carey actually did move from the family home, Connie's feelings of loss were not surprising due to her strong caregiver role in the family, Carey's decreasing participation at home and that transformation from childhood to adolescence marked a loss for the family (Preto, 1989). Connie also had increased anxiety about Carey leaving home because she was only 15 years old.

Assessing the family from a Bowen Family Systems perspective brought to light several concepts which were important to understanding the family system. These included differentiation of self, family transmission process, and triangulation. Although Carey was trying desperately to separate herself from her family of origin, emotionally she was very reactive to her mother. Her mother's struggles with depression left her with feelings of frustration that often came out in angry outbursts. Connie was equally reactive to Carey which fuelled the fire of conflict. Being emotionally reactive is associated with having low differentiation. Carey's attempts to separate from her mother did little to achieve a higher degree of differentiation. During adolescence, unresolved emotional attachment to parents comes into focus (Bowen, 1978). For a high percentage of adolescents, this period is marked by denial of the attachment to the parents and the adoption of extreme postures in order to pretend to grow up. The degree of the denial and the pretending in adolescence is an accurate reflection of the degree of unresolved attachment to the parents. From this perspective Carey would be seen as having a high

degree of unresolved attachment to her parents. She denied this and tried to emotionally distance herself by physically distancing herself. Recently, Carey had attempted to move out of the province or to another residence. This was her way of pretending to be more independent than she was.

Another outcome of being cut-off or distanced from one's family of origin was the vigorous effort adopted to create a "substitute" family from one's social relationships (Bowen, 1978). Carey defined her social and dating relationships as important parts of her life. These relationships can serve to reduce anxiety, however, when they become significant the relationships become duplicates of relationships to their parental families (Bowen, 1978). Problems occur when the adolescent encounters stress, and anxiety increases. At this point they cut-off from their new substitute family and seek others. This pattern can be repeated throughout the life cycle and eventually can become more and more isolating for an individual. Taking this into account, substitute families look like poor substitutes for one's own family of origin. Assessing Carey from this perspective highlights some of the short and long-term possibilities resulting from cut-off or distancing.

Treatment Goals and Objectives

1. To decrease conflict between the parental and child subsystem.
2. To increase the role of the executive function by encouraging Connie to seek support from her husband.
3. Access and uncover key emotional responses that underlie the interaction patterns within the family system, especially related to emotional and physical distance.
4. To help Connie and Carey discuss age appropriate rules and expectations.

Intervention

Carey and Connie attended a total of five sessions, throughout the course of three months. Two of the five sessions involved assessment and termination. This left three sessions for family work to be done. Carey's father was unable to attend sessions due to his job. Despite invitations for the grandmother to attend, this never occurred. As a result, interventions aimed at strengthening the executive function were a more difficult task (Goal #2). Every session I encouraged Connie to share what we had discussed with her husband. Opening up the information to the other half of the executive subsystem was integral to allow for communication across the parental unit. Jim was relatively unavailable to parent Carey, however, sharing this experience allowed for Jim to have some part in family therapy.

The main focus of the work revolved around slowing down Carey and Connie, thus breaking the cycle of arguing (Goal #1). In sessions Connie would frequently lash out at Carey and berate her behaviour. Interrupting this cycle became an important part of relieving in-session tension and educating Connie about the importance of listening. Communication was the focus; I encouraged Carey and Connie to talk about their own experiences and not each other's. It was difficult to stay on topic during sessions and frequently the session turned into conflict mediation.

EFT was used in conjoint and individual sessions in order to uncover and access emotions relating to Carey's distancing from her family of origin (Goal #3). I decided to meet individually with Carey, because I sensed she was not being open with her thoughts and feelings and shying away from some subjects. She would not discuss her experience of her mother's depression in conjoint sessions. Instead, she protected her mother's

feelings regarding the impact of depression. In individual sessions she shared the difficulty of living with a depressed mother. She was able to share her anger and frustration over her mother's depression. Carey distanced from her mother as an escape from the stresses of home life.

The techniques of validation and empathetic conjecture were used to draw out emotions that were over regulated and unaccessed. By listening and validating Carey's experience, I found her demeanour softening and she was able to share her fears about leaving home and her worries about her mom. Carey used distraction and talking about her mother as a way to avoid painful feelings. When I asked her to expand her thoughts and talk about her experience and not her mother's, sadness was seen in her eyes and her posture. She became tearful and was able to share that it was difficult to see her mother upset. Furthermore, she shared that distancing was her way to protect herself.

Connecting to other services was an intervention used to meet Goal #2 and Goal #4. In conjoint sessions we discussed the possibility of Connie attending a group for depression. Referral to the group was deemed important to accessing support for Connie, and allowing Carey an opportunity to see her mother receiving help. A recurring theme was Carey's view that Connie was not getting any better. Carey related her mom's lack of outside interests and friends to her mother's struggle with depression. Carey agreed that her mom attending a group might decrease her own worries about her mother. Although Connie changed her mind about the referral in the last session, this intervention helped to bring to light Carey's worries. It may seem basic and simple to refer an individual to group therapy for depression, but it is an important element in accessing support for a family.

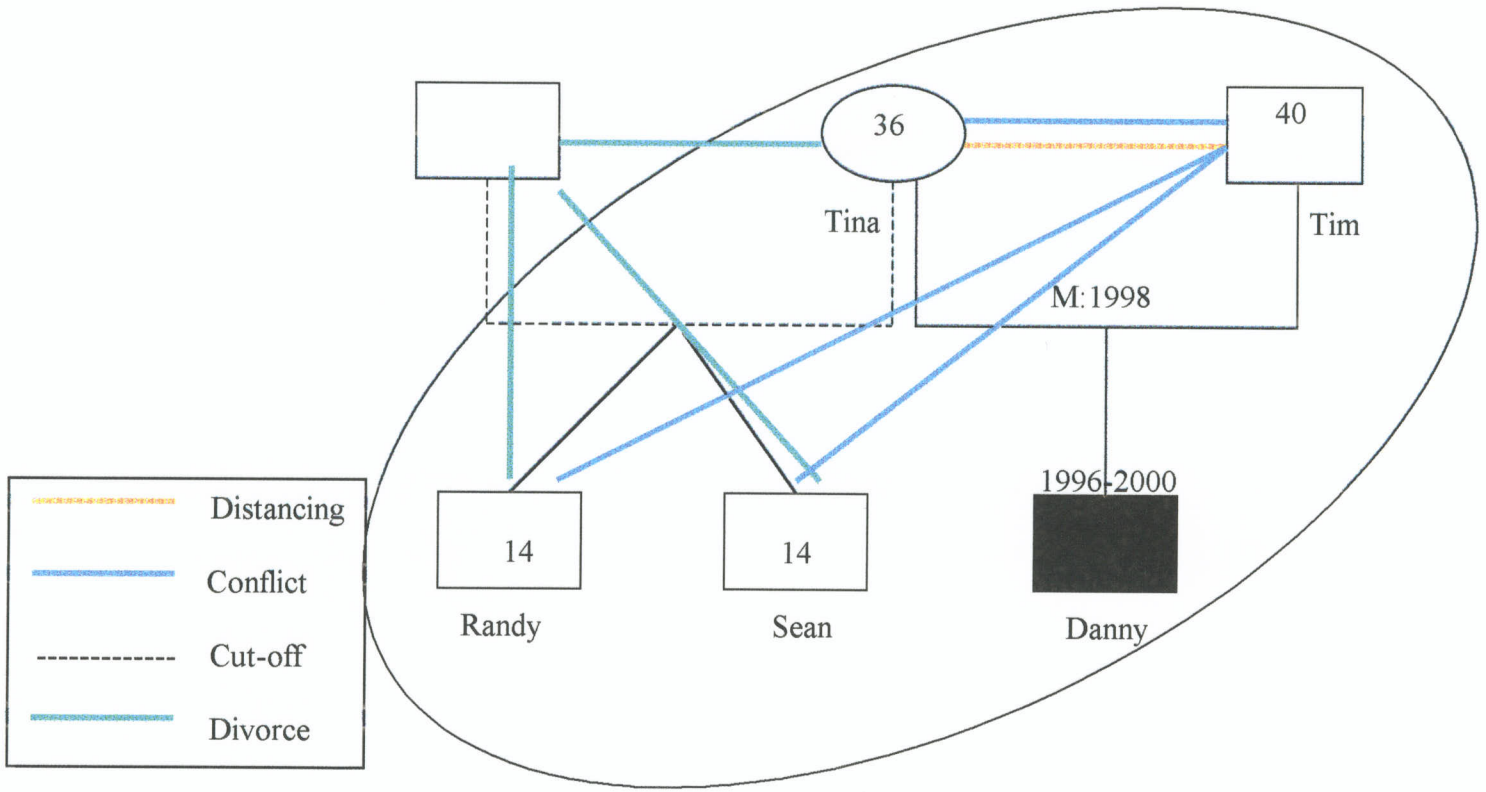
Outcome

Therapy did not occur as often as anticipated due to several cancellations on the client's part. As a result, the outcome of therapy did not meet all of the original goals of therapy. The goals that were partially met were Connie's increased support from her husband, although the process through which this occurred is uncertain. It was discussed in therapy that Carey's father should be kept abreast with family issues in order to increase his executive function. This may have resulted in Connie's increased sharing of the difficulties she was experiencing with Carey.

Therapy also provided an opportunity for Carey and Connie to express over-regulated emotions. Connie was unaware that Carey worried so much about her. Carey and Connie also worked on developing more effective communication. This was consistently demonstrated in therapy by interrupting the cycle of arguing that frequently occurred. Listening and trying to maintain emotional neutrality were encouraged.

It was unfortunate that there was insufficient time to provide a systematic intervention which may have included immediate and extended family and consultation with Connie and Carey's therapists. This information would have allowed for a collaborative intervention that was consistent with the individual therapy they were receiving. Carey's goals for individual therapy were never discussed. Furthermore, whether these goals were compatible with the goals for family therapy remains unknown. For example, if the messages that Carey received during individual therapy were to separate from her family and disconnect from her mother, this would have been incompatible with the goals of family therapy that focused on reconnecting in order to differentiate.

Figure 3: Family #3 Genogram



Family 3: The Richards

The Richard family consisted of a 36-year-old mother and wife (Tina), a 40-year-old father and husband (Tim), and 14-year-old twin boys (Randy and Sean) (Figure 3). The family had recently experienced the accidental death of their 3-year-old son and brother (Danny). At the time of Danny's death Tim was responsible for watching Danny. Structurally, the family was a blended family. Tim was not the biological father of the twin boys, but was the father of Danny. Their own biological father had no contact with the twin boys due to past abuse issues. Randy and Sean's father had physically and emotionally abused Tina.

The couple had been together for the past five years and had experienced many stresses during this time (e.g. unplanned pregnancy, alcoholism, financial stress). Additionally, they had conflicting work shifts that limited the amount of time they spent together as a couple and as a family. Recently, the couple contemplated a separation due to marital conflict. This was identified as the primary problem, and parent-child conflict as a secondary problem.

Assessment

The Richards were assessed from a Grief Approach, EFT, and Bowen Family Systems Theory. The inclusion of grief work was specifically focused on exploring the traumatic loss of a child. Although the presenting problem did not include difficulties in the grieving process it was an important area to explore due to the impact of death on relationships. The death of a child is such an extreme loss where the family's routines are destroyed or disrupted and internal working models are no longer appropriate (Riches & Dawson, 2000). Tina and Tim both identified that since Danny's death they had distanced

from each other. They frequently cried in isolation and rarely expressed sadness together. Tim felt that if he cried at the same time as Tina he could not comfort her. Coping with grief had become an individual experience where the couple had distanced from each other.

Tina and Tim grieved in different ways. This was partly due to gender differences and their individual relationship with Danny. The literature states that it is common to find mothers and fathers who seem to grieve differently (Riches & Dawson, 2000). Fathers may feel strong internal pressure to keep control of their emotions and to support family members. Research by Riches and Dawson (2000) suggests that tension may arise from differences in the way each partner expresses and manages their feelings. Differences in grieving behaviour can get in the way of normal channels of communication and can increase resentments that may have existed prior to the death.

From an EFT approach, sharing of emotions and distancing from each other were problematic. Both Tina and Tim were very tentative about sharing negative emotions with one another. Expressing these emotions in public and with each other could result in exposing each of their vulnerabilities. In one of the early sessions, Tina shared her doubts over Tim's commitment to their marriage. This was an important starting point for exploring her feelings of inadequacy and rejection. However, once this was shared, Lisa downplayed her feelings by saying it really was not a problem anymore.

Two types of negative interactional patterns were observed in the couple system. One involved a pursue/withdraw dance. This became apparent during the first few sessions when Tim would approach Tina to get close and then pull back and attack in anger when his need for closeness was unmet. It was clear that Tim wanted to get

emotionally closer to Tina, but she put up a wall that blocked opportunities for closeness. This was a pattern that was played time and again in the couple system. When the couple was asked about the pursue/withdraw/attack/defend pattern, they both identified that it was occurring.

A second pattern that was more prominent between the couple was a withdraw/withdraw pattern. Neither couple pursued the other; instead they simply avoided each other. There was a lack of communication and they rarely engaged in activities with each other. The pattern of withdraw/withdraw was strongly associated with the couple's nuclear family emotional process. Tina and Tim emotionally withdrew and distanced in order to handle anxiety. Ignoring or avoiding one another helped them to avoid discussions of conflictual matters. Both individuals had adopted ways of distancing themselves. Tina would read books; Tim took this as a sign not to interrupt. Tim distanced by putting all his energy into his work.

The couple's interactional patterns were common due to their traumatic loss. Couples who have been traumatized often become constricted into self-reinforcing relationship cycles of pursue/withdraw and attack/defend (Johnson & Williams-Keeler, 1998). These patterns make positive emotional engagement literally impossible.
The grief the couple was experiencing was not an area of open conflict, but did raise their anxiety. Tim and Tina had adopted separate ways to cope with their grief. For example, Tim grieved alone and away from Tina. Tina felt isolated and rejected that Tim chose not to share his grief. Intrinsic in their coping orientation was also an element of gender stereotypes. For example, Tim felt that sharing his feelings and emotions was of no use, while Tina saw value in opening up emotionally.

Treatment Goals and Objectives

1. Enable Tina and Tim to grieve the loss of their child.
2. Access and uncover key emotional responses that underlie the interaction patterns within the family system in order to strengthen the attachment bond between Tina and Tim.
3. Help Tina and Tim discuss marital expectations and needs.
4. Create a softening of emotion in order to facilitate communication and attachment.
5. Strengthen the relationship between Tina and Tim by encouraging them to schedule time to spend together.

Intervention

In this family, the parents were seen without the adolescents. The rationale was that the parents were experiencing difficulties in their marital relationship and involving the children was not appropriate at this time. One might feel then that this was more couples therapy than family therapy, however, one of the problems facing these parents was that they were experiencing difficulties in parenting their children. By working with the parental/couple subsystem prior to the conjoint family therapy, the goal was to rejoin the parental and couple subsystem in order to develop a more supportive parenting coalition.

The majority of the work with the couple involved exploring their experiences related to their child's death. This meant doing some grief work, using the techniques of EFT, Narrative therapy, and Bowen Family Systems Theory. Lindemann has defined grief work as consisting of: (1) the acceptance of the pain and loss, (2) open expression of sorrow, hostility, and guilt, (3) understanding the intense feelings associated with the loss, and (4) eventual resumption of normal activities and social relationships without the

person lost (cited in Hoff, 1978). He believed in the necessity of people experiencing grief in order to work through and resolve their grief.

Part of the grief work involved exploring individual narratives regarding grief (Goal #1). By studying the narratives of bereaved parents, we are able to find out in their own terms what they have thought about and what is important to them (Rosenblatt, 2000). The words that parents use to discuss loss and grief shape and create their grief. Furthermore, their narratives define their needs and are tools available for problem solving. Language is what they use to work through or fail to work through their shared realities about the death and differences between them. If differences do arise, narratives help people to come to terms with the differences. Tina and Tim were sharing small parts of their grieving experience, however, the differences in their narratives were seen as stumbling blocks in their relationship. Tina experienced Tim's lack of emotional openness as a rejection of her.

The narrative that Tim had for his grieving experience allowed him the freedom to grieve separately from Tina. He felt that two people grieving together were not an effective tool for dealing with grief. Furthermore, he felt that the best way to work through the grief was to "buck-up". Narrative therapy allowed the couple to explore their experiences and grief stories in a safe therapeutic environment. Differences in narratives were explored as alternatives in grieving and not inherently problematic for the couple. This process allowed a new opening for communication and a new understanding of different grief narratives.

Another goal for therapy was to access emotions which maintain the negative interactional patterns of withdraw-withdraw and attack-withdraw (Goal #2). In order to

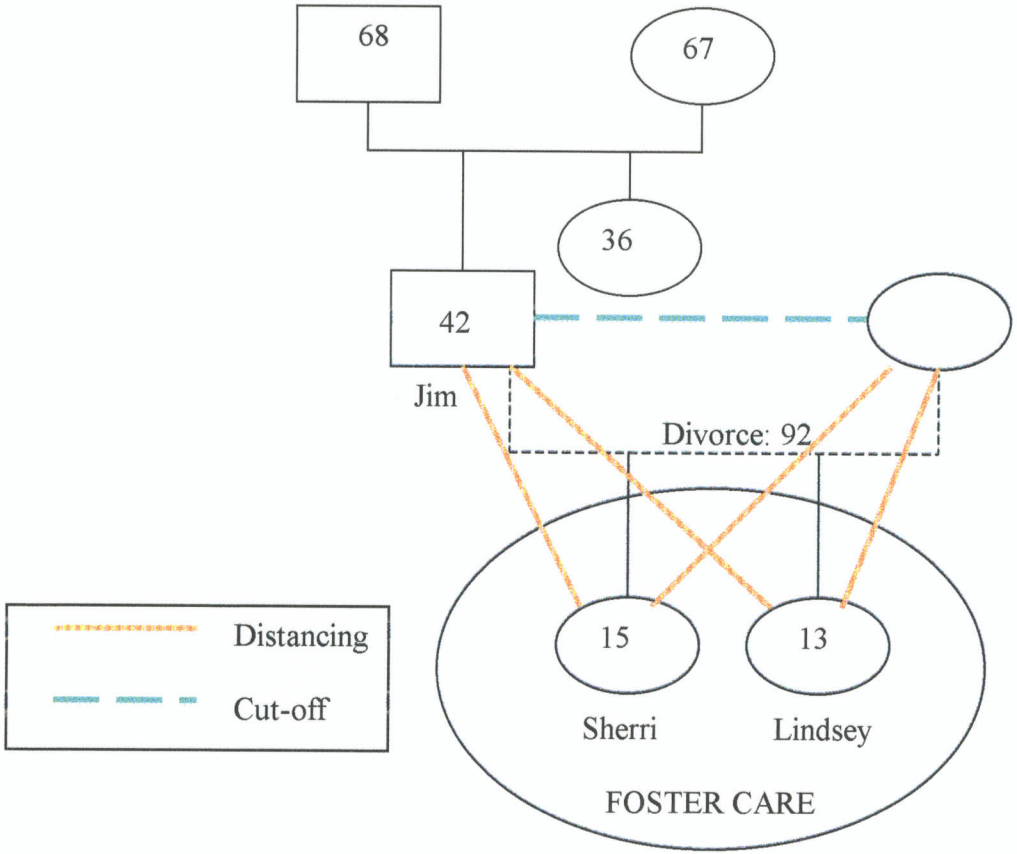
uncover the emotions wrapped up in this pattern, the techniques of reflecting, validation, evocative responding, heightening, and empathetic conjecture were used. An example of empathetic conjecture occurred when I noticed that Tina furrowed her brow in response to Tim's response to a question. I used her nonverbal cue to bring out her experience so that it could be explored. The techniques of EFT worked together to uncover the negative emotions that kept the couple at a distance.

Another intervention involved giving the couple homework. Although homework usually is not a part of EFT, it was decided that part of strengthening the attachment bond required couple work outside of therapy (Goal #6). The couple was encouraged to plan for time together. This was not homework that was to be carried out by both spouses, with no one, taking more responsibility, than the other. The couple was successful at planning time together. This task helped to strengthen the couple subsystem.

Outcome

At the end of our sessions together I could see marked changes in both Tina and Tim individually and as a couple. They had worked hard to stay with the difficult and painful emotions of loss, but continued to struggle with this very traumatic experience. . This allowed for a partly shared experience of grieving to emerge. The couple subsystem was allowed the opportunity to tentatively explore attachment needs in a safe environment. The intention was to allow vulnerabilities to emerge and a chance for the couple to work on their marriage and to confront together the loss they had incurred. This helped to encourage a stronger marital subsystem. Although their twin sons were not included in sessions, it was assumed that the steps taken to strengthen the couple subsystem would have helped to build a supportive network in the parental subsystem.

Figure 4: Family #4 Genogram



In-depth Case Studies

Family #4: The Lodges

The Lodge family consisted of a 15-year-old adolescent (Sherri), a 13-year-old (Lindsey), and a 42-year-old father (Jim) (Figure 4). The identified patient was Lindsey. She was acting out behaviourally (ex. missing curfew, involved with drugs and alcohol) and had poor school attendance. The two girls had been in foster care for the past four years with the same foster mom (Judy). Prior to placement in foster care, the two girls had experienced sporadic living arrangements and separations from their biological mother and father. When Sherri and Lindsey were 12 and 10 respectively, they moved from their mother's home into a foster placement. Since that time, the girls' biological mother lived outside the province and had infrequent contact with the girls. In addition to separations from both their father and mother, the adolescents had also been exposed to an upbringing which included drug and alcohol abuse.

Their father, Jim, was struggling with rebuilding a relationship with his daughters. Jim was employed full-time and had worked hard to develop a stable life for his girls. In addition to the family seeking conjoint therapy, Lindsey was receiving individual therapy. Family therapy was requested to facilitate the re-connection between Jim, Sherri, and Lindsey.

Assessment

As with the other families seen during this practicum, EFT, Bowen Family Systems Theory, Structural theory and Family Life Cycle were used to assess the family system.

Bowen Family Systems Theory

In terms of Bowen Family Systems Theory, the genogram carried out in an individual session with Jim provided an insight into the family structure and relationships between family members. A consistent theme throughout the family was the pattern of cut-off and distancing. Jim had been cut-off from contact with his ex-wife for the past seven years. Although he tried to correspond with his daughters, it was not until the last five that he was able to get in touch with them. In the past four years, Lindsey and Sherri's mother had vacillated between being totally cut-off from the girls and maintaining sporadic contact. Sometimes she called or sent letters to the girls several times a month, while other times there was no communication for months.

The level of differentiation was difficult to establish for each individual family member. The family was very protective in sharing information about family of origin issues. Jim shared information on his family, however it was general information on which he was unable to expand. As a result, the level of differentiation for the family was determined by stringing together the information Jim had shared. When Jim was eighteen he left home and travelled for six years. This seemed to be an attempt to distance himself from his family. During this time he never returned home. This may have seemed like a normal rite of passage for a young adult. However, when this information was combined with Jim's relationship with his father, a clearer picture of differentiation emerged. Jim's relationship with his father was marked with conflict. As a father and son "they did not work well together". His father was never around; when present he asserted his strict parenting style. Jim did not agree with his father's style of parenting. From this perspective Jim's six year separation from his family was probably an attempt to increase

his independence. This cut-off left Jim with a lack of support and unresolved emotional attachments to his primary caregivers. It was hypothesised that Jim had a low level of differentiation from his family of origin.

The basic level of differentiation of Lindsey and Sherri's mom was difficult to determine, because she was separated from the girls and was not a part of therapy. Taking into account that couples marry someone who is relatively at the same level of differentiation (Bowen, 1978); it was hypothesized that her level of differentiation would be similar to Jim's. Additionally, multigenerational transmission process tells us that the level of differentiation in the parents is transmitted to the children (Bowen, 1978). As a result, Lindsey and Sherri also had a low level of differentiation. One factor that complicated this matter was the fact that the girls did not live with their biological parents consistently. For the past four years they lived with their foster mother and her children. To what degree this influenced level of differentiation was unknown.

Emotion Focused Therapy

The family had experienced several cut-offs that had severely compromised the development of a secure bond between parent and child. Seven years ago Jim had moved away from the family home to another province. After his removal from the family, his ex-wife denied him contact with his daughters for three years. Any attempt to send correspondence or contact the girls was blocked. Four years ago the girls moved from their mother's home to their maternal grandparent's. This resulted in a separation from their mother. Less than a year later the girls were placed in foster care and once again were separated from their family. This had been their home for the past four years. The

over-riding theme was cut-off and distancing from primary attachment figures and extended family.

The hypothesis being tested in therapy sessions concerned Jim, Lindsey, and Sherri's fears about re-connecting due to past separations. Lack of trust in their father, sense of abandonment, and unresolved questions and emotions also kept the relationship between Jim and his children at arm's length. Jim had doubts whether the girls wanted him in their lives. This related to his past attachment history. He had experienced several dramatic separations which resulted in him having difficulty trusting others. One of the major separations was being cut-off from his children. He described this experience as "someone ripped my heart out". His fears about getting close to his daughters again and potentially being rejected froze him into a position of distance.

Lindsey was able to share some of her pain and fear that dad would leave again. She knew deep down that he would not leave again, but still experienced anxiety and fear that old patterns would resurface. Her pain was not associated with the action tendency to prevent harm, but it did have a survival value (Greenberg & Pavio, 1997). It was experienced only after the damaging event (i.e. parental separation) had occurred. Lindsey's pain told her that her dad had left before, so in order to prevent further pain she was emotionally and physically distant from her father.

Sherri did not verbalize any anger or fear about being re-connected. However, she came across as trying to be grown-up and independent. She was trying to cut herself off from the possibility of building a closer relationship with her father. She stated that she could take care of herself and denied that past separations were an important issue. It was hard to believe that such dramatic cut-off from one's primary caregivers had not resulted

in unresolved emotional attachment. It was hypothesised that Sherri dissociated in order to block painful emotions.. The avoidance of pain and other primary emotions was ego protective, however, if it became chronic as in Sherri's case, it could result in numbness, detached self, and disconnection (Greenberg & Pavio, 1997). This would separate the individual from their primary orientation and response system.

Individuals who have experienced trauma and the associated fear and anger in a context of helplessness learn to cope with the pain by pushing it away or by unconscious dissociation (Greenberg & Pavio, 1997). Parts of the self that contained the painful emotions were blocked from awareness. Children in unstable environments, such as Lindsey and Sherri's, learned that it was dangerous to be open about their feelings and, therefore, vulnerable.

The pattern of interaction was quite fixed and predictable. When Jim started to get closer to his daughters, they began to distance themselves by not visiting or calling. As a result Jim would distance, because he interpreted this as a rejection and a sign that they did not want anything to do with him. The girls also played the dance of pursue-withdraw. They would get closer to dad, and then distance themselves. It was interesting that the interaction was always opposite for each girl. For example, when Lindsey pursued dad, Sherri was in a position of distance. It seemed that the insecurity in their relationship with dad also involved components of sibling rivalry. When one daughter was closer, the other would distance to show her independence. What was interesting about these patterns was that it was not limited to the family system but was played out with other systems, such as with the therapist/client relationship.

Jim did not meet requests for support and comfort. He had been distant from the girls for so long that he was unsure how to comfort them. He felt that his place in the family had been replaced, and he felt dismissed as a parent. When the opportunity for comfort arose, he did not take it upon himself to comfort his daughters. For example, during one session, Lindsey was very emotional. Jim did not physically or emotionally comfort her. This stemmed from his fear that his advances would be rejected. Another factor that impeded Jim's ability to provide comfort was that he did not receive the cues from Lindsey that she needed comfort. Lindsey did not display cues that she needed to be comforted by Jim. Lindsey's internal working model taught her not to trust others, and to avoid seeking comfort from others or relying on others (Greenberg & Pavio, 1997).

Structural theory

The structure of the family was complicated. The girls lived in a foster home, but also had three other families: one that included their mother, one that included their father, and a third that included their maternal grandparents. Each of the family structures had different boundaries. These required the girls to take on different roles, and provided different levels of support. All four of these family structures were intertwined; however, for the purpose of therapy, the primary family structure examined involved the girls and their father.

The boundaries between the parent and child subsystem were fluid. Jim lacked authority in the girls' life to have parental input. The majority of time he was unsure of his role. Additionally, he felt "in the dark" and always the "last one to know". These factors made it difficult for Jim to build a more rigid boundary between himself and his

daughters. He lacked a clear role, and was not seen as a consistent fixture in the girls' lives.

Treatment Goals and Objectives

1. To strengthen Jim's role as father to Sherri and Lindsey.
2. To facilitate communication between Jim, Sherri, Lindsey, and Judy.
3. Access and uncover key emotional responses that underlie the interaction patterns within the family system to increase attachment between Jim, Sherri, and Lindsey.
4. To decrease separation and increase the attachment bond between Jim and Lindsey.

Intervention

This family posed some initial challenges in terms of engaging and joining the family and structuring therapy sessions. EFT believed that the initial session should include all family members (Johnson, 1996), however, I was unsure whether to include the foster mom in this initial session. It was decided that because the purpose or focus of therapy was to re-connect dad to his daughters, the inclusion of the foster mom was not necessary at the beginning. This did not negate the fact that in order to be helpful to the family, the foster mom needed to see the importance of family therapy. This was accomplished by meeting individually with the foster mom. I was able to bring Judy on board and build an alliance that helped to facilitate the process of therapy. Family therapy involved conjoint, individual and dyadic sessions.

The beginning of therapy involved conjoint family sessions and individual sessions with the parental and sibling subsystems. During this time, Jim and Lindsey's distant relationship became a focus of therapy. Lindsey was experiencing various behavioral and school related problems and lacked a relationship with her father. Sherri was more

connected to her father. As a result, dyadic sessions focused on strengthening the relationship between Jim and Lindsey. This did not mean that Sherri and Jim's relationship was without problems. There were still strong emotions related to past separations that kept the relationship at a distance. However, conjoint family therapy did not seem like the best forum to build on the parent-child relationship. Each girl needed separate time with their father to overcome past hurts.

Building therapeutic alliance

Some may feel that building a therapeutic alliance was only a precursor to intervention. I would argue that taking the time to build a strong bond was essential to further work, and was an intervention in itself. In the first conjoint session it was apparent that Jim lacked trust and was suspicious of outside professionals. It was imperative that in order to be helpful to the family, an alliance had to be formed with the father. Furthermore, the benefits of being re-connected had to be explored with him. In addition to meeting individually, it was also helpful to explain how my services were separate and distinct from Child and Family Services. Since his past experiences with CFS had been seen as being less than helpful, it was important to make this distinction.

The building of the alliance was also strengthened during three individual sessions which highlighted Jim's strengths. These included his unconditional love for his children, his persistence and patience. Jim had waited four years for the opportunity to be a part of his girl's lives again. Although he felt helpless at times, he never gave up the dream of being a part of their lives. Lastly, using the techniques of EFT strengthened the alliance as I consistently reflected on his commitment to his daughters, and validated his feelings of loss.

Building an alliance with Lindsey and Sherri was a slow process and involved the use of different settings. It was very difficult to engage the girls as they had short attention spans and found the therapy experience to be uncomfortable. They were unsure about its purpose. In order to build a bond with the girls, I gave them the opportunity to choose where they wanted to meet. This helped to open the doors to communication. Being more comfortable in a public setting, they shared much more than the hospital sessions. In addition to setting changes, we also spent half of the session discussing their interests. This helped to lighten the mood of therapy and provide an opportunity to get to know them better.

In the beginning of therapy there was not a strong therapeutic alliance; the family was not willing to openly share their past hurts. As a result, I was not able to access the strong emotions which resulted in the distancing of Jim from his girls and vice versa. In order to affect change in the attachment relationship, it was imperative to access the hidden negative emotions that maintained the pattern of distancing (Johnson, 1996). The family presented with a lack of emotional reactiveness. They controlled their emotions and had a flat affect. In early sessions, Jim was very pleasant, while the girls had an edge to their personality. As the therapeutic alliance was strengthened, this sharpness melted away. Sherri still maintained a wall that prevented her from sharing her emotions. Lindsey became more emotional and opened up her vulnerable side.

Strengthening the attachment bond

In order to increase the strength of the attachment bond between Jim, Sherri, and Lindsey, unaccessed emotions had to be brought to the forefront. Uncovering these emotions was integral to Goals #1, 3 and 4. These goals served to re-establish the

attachment relationship as a safe, and important component of the family system, and to facilitate open communication. Although the girls believed that they were already connected to their father, it clearly was not a strong relationship. The girls were sceptical as to their father's intentions which resulted in their distancing. Jim was more cognizant of his difficulty in trusting the developing relationship. He was able to share his fears and hopes for his future relationship with his daughters.

The steps of EFT were followed to a certain degree. The first four steps were part of the assessment, however, I found that they did not occur in exactly the same order or in clearly defined steps. For example, building the alliance was step one, but it also carried on throughout the intervention. This may have been part of the family's past history with helping professionals. However, I believe that the minute the focus was directed from the alliance was when the bond was susceptible to weakening.

As with the other families seen during the practicum, following the steps of EFT provided to be difficult and at times frustrating. With this family, the first four steps were followed, however, the later steps were found to be interchangeable in order. For example, at the beginning of each session, we reverted back to step #3 (i.e. accessing the unacknowledged emotions). From here, we usually moved to step #4 (i.e. reframing the problem), and step #5 (i.e. promoting identification of disowned needs). For the majority of sessions, this is where we usually ended. It took a sufficient amount of energy for the clients to express the unacknowledged emotions. This usually left them feeling exhausted. We never reached a point in therapy when the clients were able to promote the acceptance of their disowned needs to another member of their family. For example, Lindsey never faced her father and expressed to him her disowned needs. I was not

surprised that we were unable to move to this point, since it took a long time for her to express unacknowledged emotions. EFT was to be implemented in 8 to 20 sessions (Johnson, 1996), however, for this family, twenty sessions were more the minimum than the maximum number of sessions. Part of the reason for the increased number of sessions included: family history (i.e. numerous separations and broken trust), and an adolescent clientele that had difficulty crystallizing new information.

In order to get a clearer view of how the EFT techniques can be used to access emotions and interactional positions a short excerpt of a session will be explored. A good way to start to access emotions was to reflect on the general experience of the client in a tentative way. For example, reflections were used in a dyadic session with Lindsey and Jim. Lindsey's experience was reflected on:

> Therapist: It seems that there are two parts of you, one part that wants to be closer to your dad, and another part that is scared at being hurt again.

Lindsey agreed with the reflection. She was then validated for the difficulty of the situation; how strong they were to open the door even slightly to this possibility. In order to put her experience into a framework of attachment process and underlying vulnerabilities (Johnson, 1996), her experience was reframed.

> Therapist: So when you feel afraid at being hurt again you withdraw from dad in order to protect yourself, is that right?

Lindsey agreed with the reframe, it brought to light her fears and connected them with the interactional dance she played with her father. This topic was very rich and provided a real therapeutic focus. In order to stay with the topic and to include Jim, evocative

responding was used. This helped to solidify the client's experience in a more differentiated way (Johnson, 1996).

Therapist: What happens to you, Jim, as you listen when your daughter talks about how much she wants to be close with you, but is scared to be abandoned again?

One of the main interventions used to heighten and evoke more emotion was to focus the clients on their personal experience. In many cases individuals talked about the behaviour or feelings of other family members rather than their own. By directing their attention to their own feelings clients were able to create a new opening for knowledge. In sessions, Jim and Lindsey were asked to ground themselves in their own experience. When they reverted back to talking about the other, they were redirected back to their personal experience.

Another intervention used to increase the emotional experience of the client was to slow down the processing of their experiences. This allowed the client to experience their emotions to a greater degree. Many clients tried to move quickly through the emotion, because it was too painful. By guiding the client to stay with the emotion, painful experiences were processed to a greater degree.

An important component to strengthening the attachment bond involved creating the opportunity for closeness. When painful emotions were present, the need for comfort and closeness was often required but not implicitly given by other family members. For example, in a session with Jim and Lindsey, Lindsey began to share the painful emotions. She was encouraged to stay with the emotions while Jim was brought in to provide her comfort. I asked Lindsey if it would be acceptable if we moved closer to her for support. She agreed, and we moved our chairs closer. This new arrangement brought about a

nervous smile on Jim and Lindsey's faces. Clearly, comfort and closeness was novel to them. The fascinating part of the intervention was when Lindsey reached out to hold Jim's hand. This was a beautiful metaphor for the creation of a new attachment relationship. In this light Jim was seen as a support and comfort. He did not distance himself, but rather engaged with Lindsey.

Supporting the re-connection process was continued throughout therapy sessions. During individual sessions, I validated Jim's difficulty in re-building a relationship with his daughters. I was cautious not to give the opinion that re-connection was an easy process. We discussed that time was needed to re-build trust. This was one of Jim's frustrations. He felt that he had already lost so much time, so did not want to waste any more. By using the techniques of EFT, I was able to access emotions relating to this loss. I validated how difficult it must have been not to know if the girls were safe. This helped to bring light to his paternal instincts that these children were his flesh and blood.

Part of the work of EFT involved providing a rationale about why attachment to primary caregivers was important. This was partly psychoeducational in that the benefits of being connected were explored. Long term and short term benefits were discussed in individual and conjoint sessions. The focus was on the theme of support. I highlighted the importance of life-long supportive relationships.

The last component to strengthening the attachment bond was to encourage the family to spend time together. In individual sessions with Jim, we discussed the importance of planning time with each daughter. Shortly into the intervention he made specific plans with each daughter and increased the number of phone calls per week. Lindsey also began to drop by her dad's home for impromptu visits.

Strengthening parental role

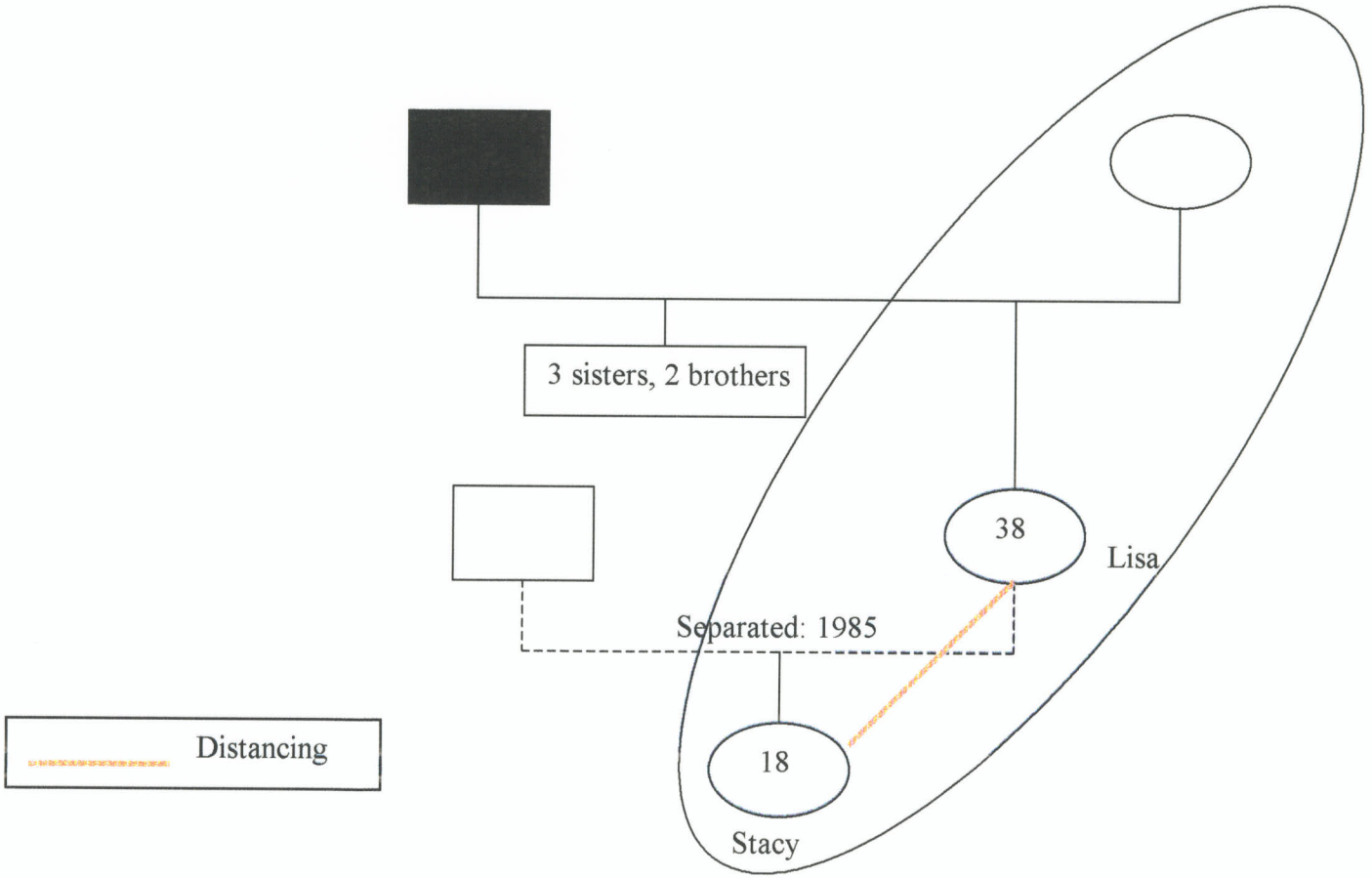
Jim's role as a parent was a focus in individual sessions (Goal #1). By meeting separately with the parental subsystem, a clear boundary was developed. We discussed issues around his role and expectations in his daughters' lives. Reflection and validation were key techniques used to facilitate the discussion. By leaving the girls out of these meetings, the division between being the girls' friend and being their father was more defined. We explored how he would become more of an active parent in his daughters' lives. For example, he would talk about some of his hopes for them (ex. staying in school, staying away from drugs). We also discussed that his role as a parent had to be slowly developed. Enforcing rules and expectations initially may have resulted in the girls' withdrawing further from him. The first priority was to re-connect and then to take on more of a parental role.

Outcome

This family was especially challenging due to the difficulty in establishing a therapeutic alliance. Once the family trusted in my abilities to support them, I was able to access strong emotions surrounding past separations. This helped to identify the negative interactional pattern which prevented closeness. All of the interventions helped to facilitate more open communication surrounding painful feelings and past separations. This helped to create a softening in order to facilitate a reconnection between Lindsey and Jim. The demeanours of both individuals had softened and a new level of comfort began to emerge. During one of the last sessions Jim supported Lindsey by holding her hand. This provided an added element of comfort and safety which was novel to their relationship.

The only drawback of dyadic sessions verses conjoint sessions was that it seemed to increase the level of sibling rivalry. Sherri became more jealous of Lindsey's time with dad. This was not an anticipated outcome. However, even with this drawback, there were serendipitous benefits for Sherri. At termination, Jim had begun to plan activities with both daughters and take on more of a presence in their life. His fears about being reconnected seemed to have decreased. This was probably a result of our conversations regarding the importance of being patient and remaining part of their lives. The use of EFT helped to facilitate Jim's ability to express the two parts of him; the one part that wanted to be reconnected, and the other that felt scared due to the possibility of being rejected. Another benefit of the intervention was an increase in Jim's parental role. At the end of therapy, Jim was able to share his concerns with his daughters. Furthermore, he began to take more of a parental role in terms of rules and expectations.

Figure 5: Family #5 Genogram



Family #5: The Gordons

The Gordon family consisted of an 18-year-old adolescent (Stacy) and her 38-year-old mother (Lisa) (Figure 5). Lisa's mother also resided in the family home. Stacy was Lisa's only child. Stacy had an uncommon relationship with her father Steven due to his frequent incarcerations. The family had experienced many separations due to Lisa's chronic physical disability. When Stacy was only five months old, Lisa was admitted to the hospital for a period which lasted one and a half years. During this time, Stacy lived with her father and his family. Lisa's physical disability had left her with paralysis and the inability to work outside the home. In addition to the physical disability which created a period of parent-child separation, there was also a period when Lisa was incarcerated. These problems compromised her ability to take care of Stacy when she was a child. As a result, Lisa's mother had always lived in close proximity, or within the same residence.

In addition to parent-child attachment issues and subsequent separation anxiety, Stacy also experienced a traumatic assault in her early adolescence. She had Post-traumatic Stress Disorder (PTSD) of six years duration. Since that episode, Stacy had seen various professionals, isolated herself in her home, and dropped out of school. She had not attended school for six years, since age 12. This incident combined with difficulties with parent-child attachment, her excessive shyness, and generalized anxiety disorder had left her on the outskirts of life.

The initial referral came to me as an ongoing case where the previous therapist was unable to continue with the family. This was a similar situation to Family #1. The main problems surrounding Stacy and her mother, Lisa, included Stacy's anxiety, parent-child conflict, and problems with differentiation.

Assessment

This family was assessed from a variety of perspectives which included EFT, Bowen Family Systems Theory, and Structural Theory. Since Stacy had been seen on previous occasions by two other therapists, there was plenty of background information on her. This was read prior to contact with the family. Included in this information was Stacy's diagnostic assessment. She had been clinically diagnosed as having PTSD and Generalized Anxiety Disorder.

EFT assessment

One important implication for EFT and Attachment Theory was the early separation of Stacy from Lisa. Lisa was hospitalized when Stacy was only five months old until she was two years old. The primary caregiver was Stacy's father, Steven. The implication of early separations, the causal relationship between loss of maternal care in the early years, and disturbed personality development has been comprehensively written about (Bowlby, 1951; cited in Bowlby, 1979). Indeed, the impact of separations has great implications for an individual. As Bowlby (1979) stated, "Once eyes are opened, it is seen that many of the troubles we are called upon to treat in our patients are to be traced, at least in part, to a separation or a loss that occurred either recently or at some earlier period in life" (p.81). It was hypothesized that Stacy's early separation from her mother and the traumatic assault that occurred when she was twelve were two factors impacting on her separation anxiety. Stacy rarely left the home without her mother and experienced moderate anxiety when left alone at home.

Stacy's attachment style was classified as anxious attachment. Early separations from her mother had left her with uncertainty as to her ability to be loved and the

legitimacy of her attachment needs. As a result, dependency on others was uncertain (Johnson, 1996). Her attachment style also had characteristics of avoidant attachment. This was characterized by a distrust of others and a corresponding desire to limit dependency on others (Johnson, 1996). The avoidant pattern influenced Stacy's behaviour. She sometimes avoided seeking support and communicating with her mom. Her mother felt isolated by her daughter's lack of sharing. The overall attachment pattern was an anxious-avoidant attachment pattern.

Although Lisa showed concern for her daughter, there was a lack of support and comfort between them. Stacy recalled times when she would try to share something with her mother, and her mother reacted with a dismissive and uninterested demeanour. Mother and daughter functioned in polarized positions of pursue/withdraw. In order to garner attention from her mother, Stacy pursued her mother. When she did not get the attention she needed, she distanced herself. This dance also occurred during arguments. They would argue, then distance from each other. In EFT terms this dance may be more appropriately termed "attack-withdraw".

Stacy was unable to recognize and validate her attachment needs. As a result she had heightened expressions of anger and anxiety that served to demand reassurance from her mother. Her mother did not provide the security in these situations and as a result Stacy felt frustrated and angry. One of the goals that Stacy had was for her mother to pay more attention and be more interested in her life. Furthermore, Stacy wanted her mother to understand her anxiety and engage in conversations with her.

Stacy's anxiety was assessed as a primary maladaptive emotion. It was generated by activation of a core insecurity or vulnerable sense of self (Greenberg & Pavio, 1997).

Initially, anxiety may have served an adaptive function, but now resulted in isolation from herself and others. Individuals who have learned that needs are not met, as in Stacy's attachment history, are resigned to feel that "It's no use, I never get what I need, and give up". The markers for identifying primary maladaptive anxiety from secondary anxiety are a longing for connection, interdependence, freedom, spontaneity, as well as the desire to be less cautious and take more risks. Stacy's goal for therapy included being more connected to her mother.

It is interesting to note that primary anxious self-organization was often indicated by an anxious-avoidant attachment pattern (Bowlby, 1958; cited in Greenberg & Pavio, 1997). Stacy's sense of self had developed from an aversive attachment history. She had given up seeking attachment to her mother and turned to self-sufficiency. This had left her feeling isolated and alone. Furthermore, individuals who turn to self-sufficiency have a limited ability to explore or differentiate internal experience (Greenberg & Pavio, 1997).

It was hypothesised that underlying the primary maladaptive emotion of anxiety was an adaptive emotion of primary sadness. The sadness stemmed from the loss of her primary attachment figure during early and late childhood. Unlike primary maladaptive emotions, primary adaptive emotions are a fundamental state for which the adaptive value is clear (Greenberg & Pavio, 1997). Stacy's detachment from her emotions and difficulty in staying with the pain were signs of suppressed sadness and emotional pain.

Bowen Family Systems Theory

Stacy and Lisa had a low level of differentiation. As a result, there was a large degree of emotional reactivity and a lack of autonomous functioning. Stacy would

frequently get upset at her mother for not paying attention to her or not asking the right questions. Both individuals functioned together, rarely making any decisions without consulting the other. Furthermore, they spent all of their time together, even going to nightclubs with each other. Stacy's lack of differentiation was not surprising, since it seemed her mother had a low level of differentiation. An opportunity to meet Lisa's mother provided insight into her family of origin. During this session the lack of independence between family members became evident. Stacy's relationship with her mother seemed to mimic Lisa's relationship with her mother. They all seemed to be very dependant on each other; they rarely went out without one another. In addition, anxiety seemed to be a factor in the lives of all family members (i.e. Stacy, Lisa, maternal grandmother). It was difficult to see any genuine differences in personality across the three generations. The lack of differentiation was being carried across the generations through the process of multigenerational projection process. Stacy's low level of differentiation was a result of her mother's low level of differentiation and her mother's mother low level of differentiation.

Family Life Cycle Stage

Although the family should have been at the late stage of transitioning out of adolescent, they were more closely represented by the tasks of a latency-aged child. Stacy had not started to develop her independence from her mother. She rarely left the home and had only one friend in her peer group whom she saw once a month. Her adolescent days were comprised of spending time in the home, reading magazines, and watching television. Her mother did not encourage Stacy to develop independence from her and seemed comfortable in her being in a "suspended adolescence". She was not moving

towards any future goals, and her anxiety kept her outside of age appropriate activities and educational pursuits.

Structural Theory

Minuchin (1981) described two opposite poles of cohesion, namely enmeshment and disengagement. There are two extremes of the cohesion continuum, disengaged and engaged. Families can be found at various points of the continuum. This family would be placed on the extreme of enmeshment. They had a lack of individuation, rarely making decisions separate from consulting the other. During the assessment, Stacy made continuous checks verbally and nonverbally with her mother. She would look to mom for her response and approval.

The boundaries between the parent-child sub-systems were fluid and lacked a clear demarcation. Stacy and Lisa interacted more like friends than mother and daughter. They were very close to each other and played the role of primary companion to each other. They even went to bars together. There was a clear lack of age appropriate expectations. Stacy had no responsibilities in the home. Everything was done for her. For example, she was not expected to clean, cook or go to school.

Treatment Goals and Objectives

1. Facilitate open communication between mom and daughter
2. To explore emotions relating to past traumas and separations
3. Access and uncover key emotional responses that underlie the interaction patterns within the family system
4. To begin the process of Stacy's differentiation from Lisa
5. To create a more defined boundary between the parent and child subsystem

Intervention

Prior to the intervention, I spent a considerable amount of time exploring previous interventions done with the family. Much of what had been done in the past was focused on Stacy's anxiety. Past clinicians had used systematic desensitization and exposure therapy which gradually exposed Stacy to the anxiety-provoking situation. The exposure to the feared situation was a major component of the behavioural approach to treating her anxiety (Greenberg & Safran, 1987). In EFT the reduction of anxiety was the major focus, and this approach governed the way I managed emotions during the sessions. The outcome of these past interventions was that little had changed with regards to Stacy's anxiety. With this in mind, it was decided that a different approach might provide a different perspective on the role of anxiety and result in a better outcome for Stacy and Lisa. In working with this family, multiple interventions were incorporated, including EFT, Structural Therapy, and Narrative Therapy.

Modifying family relationships

EFT was used to modify the family's relationship in the direction of increased trust and closeness (Goals #1, 2, and 3). This resulted in the creation of a secure base from which children could grow and leave. The first step of EFT was to build a therapeutic alliance. Clients who are pervasively anxious are afraid of being judged or misunderstood by the therapist, and are unable to disclose their concern unless they feel safe (Greenberg & Pavio, 1997). Validating the clients' feelings, and empathetically attuning to their emotional processes strengthened the therapist-client relationship. In addition, I spent time getting to know each family member's interests and strengths.

With this family the most difficult step of EFT was accessing the unacknowledged emotions underlying interactional positions (step #3). Stacy and Lisa were very skilled at over-regulating their emotions. They both had very flat affect; emotions were rarely allowed to surface. I used the techniques of validation, empathy, empathetic conjecture, and heightening to facilitate the expression of emotions which maintained the negative interactional pattern. I asked Stacy and Lisa to direct their attention to bodily felt sensations. This strategy helped the clients to focus on the present rather than the future orientation (Greenberg & Pavio, 1997). To guide the client through the process of attuning to their bodies, questions, such as "what is the feeling", "what does it feel like in your body", "what happens to you when", "how do you feel as you listen to...", and "what is it like for you as you listen ..." were presented. Even with the use of these techniques, emotions still remained partially hidden. This made it very difficult to create an opening for reframing the problem (step #4) and changing the interactional dance (step #5).

In order to do the work of EFT, the emotions had to be accessed within sessions. Without the emotions present, it was hard to reframe the problem as an attachment issue. As a result, in each session we focused on trying to stay with emotions for longer periods of time. Part of EFT allowed Stacy and Lisa the opportunity to begin to explore their own emotions. This was a process that continued throughout the intervention. As with the other families, the EFT intervention required many more sessions than the literature states (i.e. 8-20 sessions). This family had never openly discussed emotions and had a limited range of emotions. As a result, more time was needed to access the emotions underlying the attachment dance.

Structural Therapy

One of the main interventions involved creating a firmer parent-child boundary (Goal #5). This involved allowing Stacy to speak for herself in order to strengthen the boundary. I urged Stacy to speak for herself and blocked Lisa from interrupting Stacy. This intervention helped Stacy to finish conversations without intrusion from her mother. During an earlier session, I focused my attention on engaging Stacy in the therapeutic process. This had an unexpected effect on Lisa; she became visibly upset that Stacy was being engaged. I sensed Lisa's affect and explored and heightened her emotion. She was upset that Stacy was talking about their relationship, and that she, Lisa, was left out of the conversation. This example showed the extent of the enmeshment of the parent/child subsystems. Lisa's identity was so intertwined with Stacy's, that attempts to bond with Stacy were perceived as a threat to Lisa. By using validation and empathetic conjecture (EFT techniques), I validated Lisa's concerns and emotions. We addressed her feelings of being alienated from the conversation.

Narrative Therapy

Narrative therapy was not used with the family until the 9th session when it was recommended through consultation with other professionals that the family might benefit from externalizing the problem. Narrative therapy focused on learning how experience created expectations and how expectations then shaped experience through the creation of organizing stories (Nichols & Schwartz, 1998). One of the techniques that narrative therapy used to keep families blameless was to externalize the problem. It can be very empowering to speak as if the problem was a separate entity that was oppressing everyone in the family, including the client. Neither the client, nor the family was the

problem, but, rather, the problem was the problem. Stacy and Lisa had spoke of Stacy's anxiety as if it was Stacy who was the problem, and not the anxiety. Externalizing the problem was used to separate anxiety into a separate entity. Talking in these terms was very foreign to the family. Lisa made remarks saying that she had never thought about it that way. This intervention was used to formulate a new story of anxiety and to mobilize the family to fight against the anxiety.

One of the disadvantages to the Narrative Approach at this late stage in therapy was that the family did not have time to internalize the new story. Anxiety had been seen as a part of Stacy for so long that it would require several sessions in order to facilitate the integration of the new story. However, Lisa did find the new narrative an interesting and different way to look at anxiety. This new perspective added to her limited view of her daughter's anxiety.

Outcome

This family system was very stuck. Stacy had not attended school in seven years, and had made no attempts to change this pattern. The family had also been involved with a variety of professionals who had been unsuccessful in moving the family system. It would be rare to see marked change in such a stuck system with only eleven sessions. However, I did see slight improvements. For example, Stacy was able to speak with more confidence and less input from her mother. She felt more comfortable hearing her voice and responding to questions. She was also able to share some painful emotions relating to past separations and her difficulty with anxiety. Lastly, Stacy and Lisa were exposed to a different narrative of anxiety and were encouraged to explore a wider range of emotions. As the alliance between the therapist and the family strengthened, Stacy tentatively

agreed to be assessed cognitively by a psychologist. At the time of writing this practicum report the assessment was not complete, however, it was hoped that the information would be helpful in the ongoing work with this family.

Common Findings

Separation, loss, and trauma

The separation from or loss of a loved one was a common theme across the families. The separations, losses, and traumas included: death of a son/sibling, physical assault, mental illness, and emotional and physical separation from parent(s). Separations played a crucial role in the ability of an individual to form attachment bonds with a significant other. In one case separations from primary caregivers had resulted in insecure attachment relationships between parents and children. The lack of trust and safety in the relationship influenced and accentuated the negative interactional pattern.

In one family the loss of a child had resulted in an increased separation in the marital subsystem. Prior to the loss, the couple had emotionally and physically withdrawn from each other, however, after the traumatic loss, the attachment relationship grew increasingly distant. For couples in a dysfunctional relationship, the loss of a child represented a loss of self, friend, and a buffer between spouses (Brown, 1989). In this regard, the loss of a child had extreme reverberations for the couple subsystem.

All except one of the families had experienced some form of separation or loss, however, the timing of the separation or loss differed. The timing of the separation/loss impacted on the ability to access emotions related to the trauma. One family had experienced the loss of a son/sibling within the last two years. For this couple emotions were easily accessed and did not require much energy on my part to uncover them.

However, staying with the emotions was a difficult task for the couple. The other families had experienced separations and lose across the life span. In one case, separation from a primary attachment figure occurred in early childhood. Emotions relating to this loss were difficult to access. However, after a strong therapeutic alliance was established, the adolescent was able to share her anger over her mother's lack of parenting during her adolescence.

In addition to separations which can be inherently traumatic, some of the adolescents had experienced other traumatic events (ex. physical assault). In one family, the adolescent had experienced a traumatic assault when she was only 12 years old. This event resulted in PTSD and a withdrawal from daily life. The adolescent became house bound and relied heavily on her mother for companionship. She emotionally clung to her mother. She rarely spent time away from her primary attachment figure and became anxious when left alone. Trauma had serious implications for the attachment relationship between parent and child. In families where a traumatic event had occurred, the security of the attachment bond had been compromised. Furthermore, the ability to form relationships with others including the therapist became a difficult task. The process of EFT helped to outline the emotions which kept relationships distant. Validation was an extremely useful technique to explore painful emotions. Additionally, validating the difficulty of the task (i.e. discussing painful emotions and past traumas) was integral to acknowledging the clients strength and to encourage them to continue the work of EFT.

Emotional Regulation

In terms of under and over-regulation of emotions, all of the families presented with extremes of both. Individuals with under-regulated affect who were overwhelmed by

tears, exploding with rage, or shrinking into the floor with shame, presented a different picture than an individual who over-regulated their affect by avoiding feelings, intellectualizing, interrupting emotions, or avoiding situations that evoked emotions (Greenberg & Bolger, 2001).

The ability to deal with over and under-regulated emotions was particularly challenging. Working with these emotions was equally difficult with adolescents and adults, despite the fact that parents had many more years to develop strategies to mask emotions. Families provided rationales as to why they dealt with their emotions the way they did. Some of the themes surrounding the avoidance of emotions included: being upset did not help, discussing past issues was of little use, and emotions, if shared, were difficult to accept.

The types of emotions that were over and under-regulated were different for each family. Generally, primary adaptive emotions that were over-regulated included anger and sadness. These emotions were adaptive, because they promoted empowerment or grieving (Greenberg & Bolger, 2001). Because many of the families had experienced a loss or separation, the ability to assess the emotional pain was essential to reprocessing and assimilating their feelings into a cognitive structure and view of self. This process was made more difficult because these emotions were over-regulated.

In one case emotions relating to sadness and loss were over-regulated and unprocessed by the clients. Humour was employed to block painful emotions from surfacing. When an uncomfortable topic was being discussed, the family would lighten the mood and move away from the painful emotions of sadness and loss by laughing or giggling. Under-regulation of emotion was also a commonality in this family. The

adolescent and the father expressed exploding anger. They had difficulties controlling their affect which quickly led to escalating arguments. In this family over-regulated emotion was not an easy concept to address. The adolescent had ADHD which impacted on his ability to inhibit inappropriate behaviour.

Another common way that families avoided feelings was to talk about the other family members instead of personal feelings and experiences. This was a technique used in the majority of families. Individuals in these families were not in touch with their feelings. This was observed through markers, such as holding back tears, the unwillingness to cry or go into pain, tensed muscles or averted eyes. Not talking in the first person helped to maintain a distance from painful emotions. In one family answers to questions were given with reference to the other. In other words they would answer with comments about how other family members behaved or reacted in situations. When individuals were redirected to discuss their own feelings, emotions were brought to the forefront and were able to be experienced.

None of the adolescents seen during this practicum were securely attached. Instead, they were either anxiously or avoidantly attached. These two patterns of insecure attachment were "not pathological in and of themselves; in fact, they (were) most usefully considered as a set of responses that were adaptive secondary strategies that maintained the proximity of less than ideally responsive caregivers" (Johnson & Whiffen, 1999, p. 371).

Individuals with different attachment styles dealt with and experienced emotions differently (Johnson & Whiffen, 1999). Anxiously attached individuals tended to have emotional responses that were easily triggered and overrode other cues. These individuals

lived in constant fear of losing significant others (Simpson & Rhodes, 1994, cited in Johnson & Whiffen, 1999). Anger and anxiety in particular are also expressed in exaggerated manners (Johnson & Whiffen, 1999). Two of the adolescents displayed this type of attachment pattern. One adolescent female was enmeshed with her mother, and experienced anxiety over any movement away from her attachment figure. There was a history of early separations and trauma that demanded reassurance from her primary attachment figure. Her attachment style was also characterized by periods of avoidance. She vacillated between the two styles, avoiding her mother when she perceived that she could not provide secure responsiveness.

The literature on attachment paralleled clinical findings of clients' attachment behaviour. Clients who were classified as having an anxious attachment style amplified their anxiety during stress, while individuals with avoidant styles tended to deny anxiety (Johnson & Whiffen, 1999). Furthermore, adolescents who presented with an avoidant attachment pattern had high arousal, but their expression of negative and positive emotions was blunted or masked. This pattern of attachment was developed as a way of dealing with attachment relationships where comfort was unavailable and attachment figures were a source of emotional distress (Johnson & Whiffen, 1999). Three adolescents presented with this type of attachment pattern. In one case, separations from attachment figures, neglect, and drug and alcohol abuse laid the foundation for an avoidant attachment pattern. The attachment relationship between parent and child was defined by a lack of support and trust. Although the style served as a protective function in the past, it now prevented the formation of new attachments.

Cut-off and Distancing from Family of origin

In all the families there was an identifiable pattern of distancing or cutting off from family of origin, and in some cases members of the immediate family. In two cases, the immediate family were completely cut-off from the majority of extended family members, and maintained a pattern of distancing from the immediate family. This left little outside support for the family. These families were isolated and vulnerable to stressful situations. In one of the families the adolescent had ADHD and experienced difficulties in controlling his anger. The closed off family system resulted in social and family-of-origin isolation and the restriction of external feedback (Everett & Everett, 1999).

It was interesting that in some families the pattern of distancing evident in the first and second generations of the family was continued with the third generation. In one case, the mother had cut-off from her family of origin at an early age. The adolescent daughter had a similar pattern of distancing from her mother. This was a good example of the strength of the intergenerational process of cut-off and distancing across three generations. The ability to address the issue of cut-off and distancing was difficult due to the multigenerational pattern. Cutting off and distancing had become the main strategy to deal with conflict.

Differentiation of Self

In all but two of the families differentiation of self was an important theme. The adolescents in these families were asserting their independence by emotionally and physically distancing from family relationships. The reason for emotional distancing included: maternal depression, past separations and trauma, and parent-child conflict. In

some of the families, the differentiation of self was at an appropriate age (i.e. late adolescence). At this late stage of adolescence, independence and differentiation of self was appropriate for the launching into adulthood.

One adolescent was just at the beginning of developing independence from her mother. She was very enmeshed with her mother and received no messages that it was time to develop her independence. Her differentiation had been delayed due to separation anxiety and past traumas. In terms of intervention, differentiation was a difficult goal on which to work. Prior to differentiating from one's family of origin, a secure base had to be present. For this adolescent, the attachment relationship with the primary caregiver was characterized by unresolved emotional attachment. The primary focus for this family was to uncover the emotions that maintained the negative interactional patterns. From this point, a secure bond could be developed and the adolescent could continue the process of differentiation.

In two families the adolescents were in the early and middle stages of adolescence of prematurely cutting ties, and developing independence. Neither adolescent had the skills or the maturity to be independent and separate from their family. Differentiation of self for these two was not a normal transition through adolescence, rather an attempt to escape the stresses and difficulties of family life. One adolescent experienced her family life as being extremely difficult. She attempted to separate herself physically by attempting to move away from home, but was unable to leave due to her age.

The implications of distancing or cutting-off from one's family of origin had ramifications throughout life. In both families, premature separation was explored in therapy sessions. In one family we explored the reasons behind the adolescent's

distancing from her family. Her mother's depression played a large part in her difficulty in remaining at home. Emotionally, it was difficult to see her mother struggling with depression. The goal for this family was to explore the importance of remaining connected, and the ramification of not having connection to the family. Similar to the older adolescents, a secure base had to be developed in order for the individual to differentiate.

Multiple Family Issues

All of the families seen during this practicum had family issues which were additional to their presenting problems. The secondary issues included: mental illness, marital conflict, step-father/step-child conflict, financial stress, and extended family conflict. Although these issues were not the primary focus, they complicated the intervention. The following families illustrated some of the issues associated with multi-problem families.

In one family the loss of a child was the primary problem, however, marital conflict, and parent-child conflict frequently came up in conversation. All of these issues seemed to intertwine and made it difficult to focus on one topic. The couple presented with a variety of marital concerns, however, the link to the loss of their child and the impact on their relationship was seen as an important focus. Conversations regarding parenting roles and responsibilities often were intertwined with discussions about the marital relationship. Several of the sessions focused on the loss of the child and the impact on their relationship, however, it sometimes expanded to include marital expectations and needs in general. The couple had a difficult time staying focused on their grief, as other family issues were brought to light.

In another family, the presenting problem was parent-child conflict, but the ability to focus on this issue impinged on the ability to deal with other stressors. Additional stressors facing the family included financial issues and mental illness. The parental subsystem was very strained and lacked the supports from family of origin and extended family. In order to address the issue of parent-child conflict and the other stressors, the parent subsystem was strengthened. Meeting separately with the parents and encouraging open communication accomplished this fortification.

Multi-modal Therapy

The majority of families were involved with other forms of therapy (i.e. individual, group). In several of the families, the multi-disciplinary hospital team provided the additional services. This provided an opportunity to meet team members to consult and coordinate services. In one family, consultations with the individual therapist provided insight into the client's struggles with ADHD provided a timeline of intervention and an opportunity to develop an appropriate treatment plan. The individual had a long history of aggressive behavior and angry outbursts towards his family. He lacked any insight into his behavior and had difficulties controlling his anger. This information was used to design a family intervention that addressed behavioral issues. Consultation also provided a historical view of the family's difficulties and successes, and their involvement in various support systems. The individual therapist had known the family for four years and had been actively involved in consulting with the school system. All the information garnered through consultations provided the opportunity to design a family intervention that addressed the presenting problem, and took into consideration prior therapeutic success, failures, and personal limitations.

In another family, several meetings took place with the individual therapist. This provided an opportunity to discuss areas of concern that were not brought up in family sessions, as indicated by the following. The individual therapist shared recent developments in her school attendance, and personal difficulties she was experiencing. By meeting together, we were able to identify areas of concern that were addressed in individual and family therapy. During individual sessions the client worked on developing her independence by focusing on future goals and building her self-esteem. In family sessions, we discussed age appropriate roles, expectations, and the task of developing independence.

In addition to the various intervention modalities (i.e. group, individual, family), families were seen in different forums for family therapy (i.e. parental, sibling, adolescent). Conjoint family therapy only occurred in one family. For all of the other families, family therapy involved seeing different subsystems. In some families, family therapy was conducted individually with the adolescent, parents, and sibling subsystem. Working with subsystems was a powerful tool for restructuring and redefining relationships when families with adolescents were developmentally stuck (Johnson & Whiffen, 1999). In all but one of the families, the families were seen conjointly for the first session. This provided an opportunity to meet with the family as a whole and observe patterns of communication and interaction.

In two of the families, meetings with the parent(s) followed conjoint sessions. This provided an opportunity for the parent(s) to discuss fears or worries about their adolescent and to ask questions about the process of therapy. The main goal was to create a safe atmosphere where they could feel free to be more objective about their parental

role, and to explore past struggles in other areas of their life (ex. work, being divorced, problems with family of origin) (Preto, 1989). In one family, the sessions with the father brought to light concerns about re-connecting. The father worried that his daughters did not want him in their lives. This revelation provided an opportunity to discuss his concerns, validate his worry and to build an alliance. Without meeting separately the father may not have been as invested in reconnecting with his daughters.

In two of the families, sessions with the sibling subsystem provided an opportunity to discuss sibling issues. This was important because any changes the family made to accommodate the adolescent affected the position of the other siblings in the system (Preto, 1989). In one case sibling sessions provided an opportunity to explore how the problem affected the sibling relationship. It also helped to identify possible ways to improve the situation, such as increasing time spent with other siblings.

Adolescents in three of the families were seen individually for one or more sessions. These sessions helped to develop a therapeutic alliance which was built on validation and empathetic attunement. Two of the adolescents shared feelings and concerns which were unable to be shared in conjoint sessions. This brought forth ideas that were important in therapy. One adolescent shared her frustration over her mother's depression and how this impacted on her desire to move away from home. She was uncomfortable in sharing this in conjoint sessions because she worried about hurting her mother. By validating her concern and discussing how this could be brought out in conjoint sessions, we were able to use this piece of information.

CHAPTER 6: EVALUTION

The chapter outlines the results and interpretations of the two evaluation tools used during this practicum. For the majority of families, the FAM-III was administered during the first and last session. The Post-intervention Client Questionnaire was given to clients during the last session. The evaluation of this practicum consisted of both qualitative and quantitative measures. One of the benefits of qualitative measures was gathering clients' perceptions of what was useful and helpful. The problem with using only quantitative methods was that the family may have numerically improved, however, they may not have become more functional as a result of treatment. Qualitative and quantitative methods are synergistic. Qualitative methods provide the clinician with contextual data that enriches and expands quantitative findings.

The following discussion explores the results from the FAM-III pre and post-test, and the Post-intervention Client Questionnaire. Scores on the FAM-III that are below 40 are viewed as a family strength, between 40 and 60 as normal range, and above 60 in the family problem range (Skinner, Steinhauser, & Santa-Barbara, 1995). It has not been determined how much of a difference between family members' perceptions is significant. As a rule of thumb, a 10 point differential between how family members rate the same subscale, the more likely the discrepancy is to be clinically significant. However, even a differential of 5 points may be significant if it occurs on a number of clinical parameters.

Family #1

The FAM-III pre-therapy showed that Clare and Jeff saw difficulties in multiple areas of family functioning (Table 2; Figure 6). Mike and Jodi rated the family as

functioning in the normal range. This was not surprising since they were isolated and distanced from family conflict. Mike was only at home two days a week, and frequently distanced himself during conflict situations. Jodi also distanced and removed herself from conflict situations. The lack of congruence among the profiles indicated that subsystems of the family may have had a different perceptions of their family. Furthermore, the discrepancies between Mike and Clare's scores indicated that there was a greater likelihood of marital conflict.

Jeff's scores at termination of therapy were elevated on the subscales of *Task Accomplishment, Role Performance, Involvement and Contro*l. Scores on the FAM-III post-therapy indicated that subscales rated as problematic had became more of a problem, except for *Involvement*. Additionally, *Communication* moved into the family problem range. The slight decrease in *Involvement* was probably the result of assessing the family's concerns regarding Jeff. I was slightly surprised that *Communication* became more problematic. Part of the goal of therapy was to increase the clarity and frequency of communication in the family system. Jeff's scores indicated that communication was increasingly confusing and insufficient.

Clare's scores on the FAM-III post-test revealed that in the areas that were elevated on the pre-test (i.e. *Task Accomplishment, Role Performance, Communication, Affective Expression,* and *Involvement*), either decreased or increased by 4 points, or stayed the same. These were not significant changes, however, they served to highlight that the family was still experiencing problems in multiple areas.

On the FAM-III pre-test, Mike's scores revealed that the family was functioning in the upper level of the normal range. Scores on *Role Performance* and *Communication*

were at the mark for family problems. Scores on *Social Desirability* and *Defensiveness* were elevated and indicated the possibility of distortion of the values. It was most likely that the scores were artificially depressed. If this were true the gap between Mike's scores and Jeff and Clare's would have narrowed. On the FAM-III post-test scores on *Role Performance* and *Affective Expressions* were in the family problem range, while scores on *Communication* decreased and were in the normal range. It was interesting to note that Mike's scores on *Social Desirability* and *Defensiveness* remained the same, despite the development of a therapeutic alliance.

On the FAM-III pre-test, Jodi scored in the normal range for all subscales, however, *Affective Expression* was at the point of being problematic. Her scores on *Social Desirability* and *Defensiveness* did not guarantee the validity of scores. Scores below 40 indicated that there may have been a distortion, such as projection (Skinner, Steinhauser, & Santa-Barbara, 1995). On the FAM-III post-test, *Involvement* increased into the problem range. This change may have been the result of increased communication and involvement, combined with a lack of security and autonomy among family members.

The family's responses on the Post-intervention Client Questionnaire indicated that all of the family members reported satisfaction with the counselling received, felt that I understood their problems, and were comfortable discussing issues. Some of the most helpful topics discussed included: talking together, helping to explore how family members interact with each other, and discussion of Mike's illness. The things that were important in terms of family relations were not taking things so personally, learning how to divide time with chores and family, and encouraging more communication. The most

significant ways that therapy affected the family were: more communication, more interaction, and an opportunity to discuss Jeff's behaviour, Mike's illness, and how these areas affected the family.

Family #2

From the FAM-III, it was shown that Carey and Connie were experiencing problems in six of the seven areas of family functioning (Table 3; Figure 7). These included *Task Accomplishment, Role Performance, Communication, Involvement, Control,* and *Values and Norms.* This indicated that these two family members were experiencing problems in multiple areas of family functioning. Although they viewed similar areas as problematic, the degree to which they were a problem differed. There was a large differential between Carey and Connie's scores on the various subscales. My assessment agreed with what the FAM-III showed. In particular, carrying out tasks and communication seemed to be main areas of difficulty for Connie and Carey. The communication pattern between Connie and Carey was very volatile and would quickly erupt into arguing. Neither individual had well developed listening skills and were equally reactive to the other.

High scores on *Task Accomplishment* indicated that there may have been some failure to attain objectives which were central to the functioning of the group. Functions which were not being met may have included: allowing for continued development of all family members, providing reasonable security, ensuring sufficient cohesion in maintaining the family as a unit and functioning effectively as part of society (Skinner, Steinhauser, & Santa-Barbara, 1995).

The FAM-III post-therapy indicated that Carey and Connie were still experiencing problems in the same areas of family functioning. Scores on *Task Accomplishment, Role Performance, Involvement,* and *Values and Norms* had increased, while scores on *Communication* and *Control* increased for Carey and decreased for Connie. The increase in some of the subscales was probably related to Carey's increasing problematic behaviour. She had been suspended from school, and had increased her distance from her family. She was rarely home and spent most of her time with her peer group. Connie's scores on the *Communication* subscale may have decreased due to the opportunity to discuss issues in therapy. This may have provided a temporary release and support. Scores for *Control* may have decreased because Connie had partially removed herself from overt power struggles with Carey. Connie was physically and emotionally exhausted from the constant arguing. She had adopted a new attitude that Carey would do whatever she wanted and there was no way to change her mind. At termination Connie was at the end of her rope and felt hopeless and frustrated with the situation.

Responses from the Post-intervention Client Questionnaire indicated that Carey and Connie had felt satisfied with the counselling they received; expressed that their problems were understood, and felt comfortable talking. Carey said the most helpful thing discussed was encouraging her mother to have a better understanding of their interaction pattern. The least helpful things discussed were arguing (Carey), and not being given a guide line to work with (Connie). I was not surprised by their comments, although mediation was invoked throughout the session, tensions still flared. In terms of giving a guideline to work with, the limited number of sessions and difficulty focusing on a task made it more difficult to make a clear therapeutic contract. Connie thought that the most

significant way therapy affected her family was that she found out that Carey was worried about her. In my opinion this was a very important learning experience. It provided an opportunity for Carey to share her concern and her love for her mother.

Family #3

Only the parents were seen in therapy and completed the FAM-III (Table 4; Figure 8). Elevated scores on multiple areas indicated a disturbance in family functioning. Tim saw problems in all areas of family functioning. Tina reported the same, except she did not see *Role Performance* as being problematic. Similar scoring indicated that the couple perceived the family in similar ways. It was not surprising that all areas of family functioning were elevated. This couple had experienced a tremendous loss and had reverberations for all areas of family functioning. The couple also had additional financial stress, marital conflict, and parent-child conflict.

The post-therapy FAM-III indicated improvement for Tina and Tim on *Task Accomplishment* and *Communication*. Tina's scores also approached or were in normal range for *Affective Expression* and *Involvement*. For Tim, *Role Performance, Control*, and *Values and Norms* approached or were in the normal range. These results showed significant improvement from pre-intervention to post-intervention. My clinical assessment agreed with the FAM-III results. At termination of therapy, there was increased communication, clarification of marital expectations and needs, and an increased range of affect.

The Post-intervention Client Questionnaire showed that Tina and Tim were satisfied with the counselling they received, felt that the social worker understood their problems, and felt comfortable talking. The most helpful things discussed or encouraged

in sessions were that they were "able to ask questions and clarify areas of concern that are a touchy/defensive area"(Tim), and "having a third party to mediate and re-direct"(Tina). The most significant ways that therapy affected the couple were: "some personal feelings came out that each of us were unable to say face to face otherwise"(Tim), and "a little more communication about every day things", "some thoughts and feelings"(Tina).

Family #4

At the beginning of therapy, the FAM-III (Table 5; Figure 9) indicated that Lindsey saw all areas of family functioning as problematic, while Jim saw some areas as problematic, and Sherri saw no areas as problematic. However, after looking at the scores for Sherri on *Social Desirability* and *Defensiveness*, it was shown that the scores were elevated and, therefore, answers may have been artificially depressed and the profile may have been distorted. All family members had varying perceptions of family functioning. The lack of congruence indicated the greater likelihood that family members did not share a common perception of the family, however, this cannot be confirmed due to the possibility of distortions. A possible reason for the lack of congruence was that the family was not living together and were disconnected from each other. As a result their perceptions of family functioning may not have been similar.

Similar to the pre-therapy FAM-III, the post-therapy FAM-III lacked congruence. Lindsey and Jim's scores on all of the subscales were very different. This indicated the likelihood that they still had different perceptions of family function. A second possibility was that Lindsey's responses included functioning in her family of origin and her foster family. Issues which stemmed from her foster family may have been included in her responses and complicated the picture.

Lindsey's scores on the post-therapy FAM-III indicated significant improvement on all subscales, however, scores for *Social Desirability* and *Defensiveness* indicated the possibility of distortions. This made it impossible to use the FAM-III post-test as a tool to show marked changes in family functioning. Jim's post-therapy FAM-III showed increased scores on *Task Accomplishment*. Scores on all of the other scales changed only slightly or did not change at all from the pre-therapy to post-therapy FAM-III.

Sherri did not fill out scores on the post-therapy FAM-III and the Post-intervention Client Questionnaire. Despite attempts to fill them out, they were never completed. Jim and Lindsey filled out the Post-intervention Client Questionnaire. Their responses indicated that they were satisfied with the counselling they received, felt their problems were understood, and felt comfortable talking. The most helpful things done in sessions were working on "more emotions and more openness towards certain subject". Lindsey felt that discussing what happened in the past was helpful. The most important thing Jim learned was to "spend more time and to understand everyone's feeling towards certain subjects". Lindsey learned that "I can't always shut down family". The most significant way that therapy affected Jim's family was "more communication with my daughters". For Lindsey, therapy made her actually talk about problems.

Family #5

The FAM-III pre-test indicated that Stacy and Lisa were experiencing problems in multiple areas of family functioning (Table 6; Figure 10). These included *Task Accomplishment, Affective Expression,* and *Values and Norms*. Stacy also experienced *Role Performance* as a problem. High scores on *Task Accomplishment* pointed to a failure of some basic tasks, difficulty in responding to changing family life cycle stages,

problems in task identification, generation of potential solutions, and implementation of change (Skinner, Steinhauser, & Santa-Barbara, 1995). This family was experiencing difficulties in responding to life cycle stages, but more so in carrying out the tasks of their current life cycle stage. For example, Stacy was 18 years old but had not developed an age appropriate independence from her mother or had not started the differentiation process. She was highly enmeshed with her mother and relied on her for all of life's necessities.

The family was stuck and unable to move through the family life cycle stage of adolescence. The basic tasks of this stage were never met, and did not seem to be a concern for Stacy or Lisa. There was a sense that they were more than comfortable in their static family system. This correlated with what the FAM-III showed, that minor stresses involved in responding to the tasks of adolescence precipitated a crisis. As a result, the family had remained in a state of equilibrium where family life had remained the same for the past 6 years. Stacy had not attended school or formed new peer relationships. Furthermore, Lisa had assisted her daughter in maintaining this existence by unconditionally accepting her daughter and not encouraging her to develop her independence.

The FAM-III post-test showed that *Task Accomplishment* still remained a problem for Stacy; however, Lisa's scores had decreased by 6 points. Lisa's change may have been a result of the different narrative used to explore Lisa's anxiety. This may have helped open the door to new solutions to old problems.

Affective Expression was also an area that was problematic for the family. They had difficulties communicating with each other, and presented with a flat affect in therapy.

On the FAM-III post-test, Stacy and Lisa's scores on *Affective Expression* had decreased (8 and 6 points respectively). This change was no doubt the result of EFT and its focus on emotions. Previously over-regulated and unaccessed emotions began to be expressed. This included anger and frustration. This family still had a long way to go in order to express a full range of affect, however, the groundwork had been set.

Scores on *Values and Norms* were in the family problem range for Stacy, and verged on being problematic for Lisa. It was not surprising that Stacy viewed this area as problematic. Her family's values differed from the culture as a whole. For example, Stacy had not attended school for the past eight years. Additionally, Stacy had a lack of peer relationships and was not carrying out the tasks of adolescence that are followed in mainstream society. For example, Stacy did not date, did not hangout with peers, and never had a job. On the FAM-III post-test, scores on *Values and Norms* approached the normal range.

On the FAM-III post-test, scores on *Involvement* and *Communication* increased from the normal range into the family problem range. High scores on involvement are related to family members who exhibited insecurity or lack of autonomy (Skinner, Steinhauser, & Santa-Barbara, 1995). Stacy and Lisa were very highly enmeshed and therapy may have accented this to a greater degree. Furthermore, the intervention of EFT may have brought forth individuals' insecurity regarding their lack of autonomy. With regards to the increase of scores on *Communication*, therapy may have highlighted the lack of genuine communication and a lack of mutual understanding among family members. One of Stacy's presenting complaints was that her mother did not understand

her. Although therapy helped to open up communication, it also highlighted Lisa's lack of understanding of Stacy's experiences.

The family's responses on the Post-intervention Client Questionnaire indicated that overall the family was satisfied with the counselling they received. They felt their problems were understood, and that they were comfortable discussing issues in therapy. Stacy stated that the most significant way that family therapy had affected her family was that, "We are a lot calmer with each other. We listen to each other more". Lisa felt that she had learned more about her daughter's anxiety.

Examination of Evaluation Tools

An evaluation instrument can be a beneficial tool for clinical use. The FAM-III provided an insight into a broad view of family functioning, and provided the practitioner with a baseline to explore therapeutic change. As a starting point, the FAM-III provided a check and balance against which to compare my assessment against. I found that responses on the FAM-III were similar to my clinical assessment. One of the limitations I found with this instrument was that the majority of my families were experiencing problems in multiple areas of family functioning. As a result, the FAM-III did not really prioritize where the focus should be. It was somewhat overwhelming for a beginning practitioner to see the results of the FAM-III when all areas were elevated. This was where the assessment and discussion of the presenting problem was key to teasing out the focus of the intervention.

A second problem with the FAM-III was that it was not always as straightforward as one would think. When given to some families, there was confusion as to who "your family as a whole" included. For example, in Family #4, the adolescents lived in foster

care. In this case there was the foster family, and their biological family. Some of the questions relating to *Role Performance* and *Task Accomplishment* differed depending on which family they considered. It was suggested by Skinner, Steinhauser, & Santa-Barbara (1995) that the FAM-III was done twice for each family unit, however, this made the evaluation process quite cumbersome.

The last drawback to the FAM-III was that it did not provide the direction in which the subscale was problematic. For example, if an individual scored in the problem range for *Control*, we only knew that it was too rigid or laissez-faire; extremely predictable or chaotic. This pointed to the importance of conducting a thorough clinical assessment. Without this added information, all that would be known was that the part of family functioning was problematic, but the direction would be unknown.

One thing that I found to be most useful and an important component of the FAM-III, was the *Defensiveness and Social Desirability* sub-scales. As a practitioner who saw the value in quantitative and empirically validated measures, this was an integral and immeasurable piece to the FAM-III. Without these sub-scales, one might have felt that the responses were artificially elevated or suppressed. I found that for some families, these sub-scales were elevated at the end of therapy, while for others they had decreased. Possible reasons for the elevation might have included the client feeling that they wanted to show improvement in the family's functioning. This might have been connected to a strong alliance between the therapist and client, or might have been unrelated. As for the decrease in the subscales, clients were more connected with me at the termination of therapy and were less likely to distort their responses on the post-therapy FAM-III.

The Post-intervention Client Questionnaire was a very informative tool. It provided feedback on what the clients' experiences in therapy were. Overall, the clients felt that therapy did benefit them in some way. None of the clients felt that the social worker failed to understand their problems or were dissatisfied with the counseling they received. This positive feedback was very gratifying considering that many of the families were difficult to engage and had presented with multiple problems. Although the questionnaire was brief, it still provided an important component to the evaluation process.

Evaluation of the approaches

The application of Bowen Family Systems Theory was very useful for assessment purposes. All of the concepts of the theory, especially differentiation of self and family emotional process, provided a starting point to explore family dynamics. The life cycle stage of adolescence made it more difficult to determine the level of differentiation because the characteristics of an individual with low differentiation were similar to the description of an adolescent. Undifferentiated individuals react to major life decisions based on what "feels right" or simply by getting comfortable (Bowen, 1978). Their use of "I" is confined to the narcissistic "I want", or "I am hurt". These characteristics of undifferentiated individuals may be used to describe an adolescent. Adolescents are known for their impulsivity and ego-centrism, this is part of their development towards a level of differentiation. It was helpful to gather information from three generations in order to gain some understanding of the adolescents level of differentiation.

An in-depth three generational assessment was undertaken in half of the families. This provided information on the family projection process and the level of differentiation across generations. Determining the level of differentiation required the

use of subjective information given by the family as well as hypotheses of the basic level of differentiation. The basic level of differentiation in Family #1 was determined by taking into the consideration the literature on schizophrenic offspring. Bowen's early work focused on schizophrenic families and explored the relationship to level of differentiation. The basic level of differentiation of the parents of a schizophrenic offspring is very low. As a result of the multi-generational transmission process, the offspring has a lower level of differentiation than his or her parents. Bowen's research with these families provided insight into the level of differentiation in these families.

The use of Bowen theory during assessments with these families was very appropriate due to multigenerational issues and the potential to revel multigenerational patterns of interaction. The only drawback was that it required several sessions to gather all of the information. In the families where an in-depth assessment was done, the rationale for collecting information was integral to developing and maintaining a strong alliance. The rationale for gathering in-depth family of origin information included: 1.) it would help in the assessment process, 2.) it would allow an opportunity to make a thorough intervention plan, and, 3.) it would provide an opportunity to become familiar with the family. Even with the explanation as to its importance, some families found the process tedious, and uninformative, and sometimes even uncomfortable. This was not surprising, considering that these families had marked family of origin separations and cut-offs. Their coping mechanisms had required them to cut-off or distance from their family of origin. What I was asking them to do was exactly the opposite of what they had become accustomed. Although families were never asked to go home to rectify or gain more understanding about their family, the brief look into family of origin during the

assessment period was enough to raise the anxiety in these families. This serves to display the power of cut-offs and unresolved family of origin issues. Since families were never asked to go home to gain more understanding about their families, Bowen Family Systems theory was not used as an intervention, but only as an assessment tool.

One common intervention across families was the use of EFT to access and uncover key emotional responses that underlied the interaction patterns within the family systems. Generally, the use of EFT was found to be particularly relevant to this population of adolescents' and their families who were experiencing difficulties in the transition through adolescence, or difficulties due to traumas or separations. The degree to which this was accomplished in each family differed. Families that were most receptive to this approach were Families # 1, 2, 4, 5, and 6. These families had carried with them emotional baggage which they have never had the opportunity to explore in a safe therapeutic environment. By providing an environment of validation and reflection, the clients were able to explore emotions which had been over-regulated, hidden, or placed the client in a vulnerable situation.

EFT was not widely researched and had been systematically applied only to families where adolescents between the ages of 14 and 19 were struggling with depression and/or eating disorders (Johnson, 1996). During this practicum EFT was applied to adolescents who were 12 and 13 years old, and to a population where the presenting problem was not depression or eating disorders (e.g. problems related to trauma and disrupted relationships). Overall, the application of EFT was seen as a useful and appropriate intervention for this population. Some of the drawbacks of the approach included: difficulty in applying the steps, confusion in identifying primary and secondary

maladaptive and adaptive emotions, and the number of sessions required. The first four steps of EFT proceeded in sequence; however, the rest of the steps flipped around and did not proceed in sequence.

A second difficulty with working with emotions was identifying the type of emotion (i.e. primary, secondary, instrumental, maladaptive, adaptive). During sessions it was difficult to assess the emotion and determine what to do with it, despite the fact that there was an enormous amount of literature on the types of emotions and how to work with them. One of the main focuses of EFT was to focus on primary affect (Johnson, 1998), however, determining which emotions were primary and which were secondary was not always clear. Secondary emotions were usually expressed as part of the cycle of distress, while primary emotions were usually undifferentiated, or disowned. Even with some of the difficulty in differentiating the emotions, I usually was able to separate the primary from secondary emotions. The couple in Family #3 expressed anger and frustration, however, beneath this anger was sadness over unmet attachment needs. Anger was identified early as a secondary emotion due to its constant presence in session. The couple was very comfortable with the expression of anger, but any move towards sadness was quickly averted.

A third difficulty with EFT was the number of sessions required. EFT was to be implemented in 10 to 15 sessions (Johnson, 1996), however, during this practicum the stages of EFT would have required more than the allotted sessions. None of the families finished the process of EFT. There are several reasons why more sessions would have been required for completion:

1. There was not a pure application of EFT, but rather an integration of Bowen Family Systems Theory as an assessment tool, Structural Theory, Narrative, and Family Life Cycle Stages.
2. Families presented with multiple problems and complicated the focus of therapy.
3. The application of EFT was a very difficult intervention for a novice therapist.

During the proposal stage of the practicum I had several reservations about working with the different theories, namely EFT and Bowen Family Systems Theory. First, I queried whether this approach might have been too complicated for a beginning clinician. Second, I questioned whether I would have been able to integrate the two theories while still maintaining a strong therapeutic alliance with my clients. I found that my knowledge and expertise grew enormously by exploring the two theories simultaneously. Throughout my practicum experience I consistently examined how these two theories worked independently and conjointly during assessment. I felt that if I had focused only on one theory I might not have challenged my thinking on the use of an eclectic or integrated approach to therapy.

Bowen Family Systems Theory and EFT did not adequately meet all the therapeutic needs of these families. Bowen Family Systems Theory required more time to be used as an intervention, however, it was appropriate for assessment purposes. The information garnered from in-depth genograms was more helpful with some families than others. In terms of assessment, Family Life Cycle Stage added immensely to the understanding of each family. Some of the families were at appropriate stage expectations, however, other family systems were not flexible or lacked the structure to

facilitate the entrance into and through adolescence. Structural Theory provided basic information surrounding boundaries, role expectations, and patterns of cohesion. This was important during the assessment and intervention stages. In Family #3, the inclusion of Grief Work helped to outline the development of a new narrative, to understand gender differences, and to explore the stages involved in grieving. The inclusion of other approaches brought to light the importance of a thorough assessment and individualized case plans that met the varying needs of families.

Evaluation of the Population

Working with adolescents has always been part of my work experience and one of my passions. During this practicum, the resiliency that adolescents displayed in the face of trauma, separations and the transition through adolescence was particularly remarkable. It was very easy to overlook this aspect when faced with an adolescent who was acting out aggressively or seemed to have no respect for others. By re-labelling a troubled adolescent to a resilient adolescent, I was able to join with the adolescent. This was not to say that I condoned their behaviour, but rather experienced their behaviour as an outcome of experiencing separations and traumas.

One of the most important aspects of working with adolescents and their families was to take time to build a strong therapeutic alliance. This required respecting each family member's opinions, validating his/her experience, and most importantly, maintaining a position of neutrality in the family system. It was not helpful if the family viewed the therapist as choosing sides. This may have seemed like an easy task, however, the ability to remain neutral could have been influenced by the family life cycle stage in which the therapist was. For example, this practicum required me to work with families

with adolescents. I did not have children of my own, therefore, I related more to the adolescents than the parents. Remaining cognizant of this fact helped to maintain my position of neutrality in the family.

Working with adolescents and their families also required knowledge of the tasks necessary to move through adolescence. Any assessment was incomplete without exploring how the family was accomplishing the tasks required of the specific life cycle stage. For example, during this practicum failing to view families from a life cycle perspective would have ignored the fact that this stage required parents to be flexible in order to allow for increased independence. Several of the families were experiencing difficulties in differentiation which was related to rigidity in the family system. There was not enough flexibility for the adolescent to spread his or her wings and differentiate from their family of origin. This information provided a focus of therapy which helped to alleviate family stress.

Another component that was critical to working with adolescent families was the use of a systems approach. Without widening the scope to include the school and social/peer contexts, I felt there would be a gap in the ability to meet the needs of families. The social/peer group played an imperative and very influential part in the adolescent's life. These influences may have been a positive source of support for a troubled adolescent, or may have been a source of conflict between the adolescent and his or her parent(s). Schools also played an intricate part in family life. There were areas of concern in the school setting. For example, professionals, such as teachers or social workers, were also able to provide support to the family.

In cases where a diagnosis had been made of a mental illness, or a learning disability, co-ordination and collaboration between schools and the therapy environment were keys to providing a holistic approach to meeting the family's needs. In terms of time commitment, a systems approach required a large amount of time for consultation with other areas (e.g. school, peer group). In a time when fiscal responsibility and cuts to health programs have become commonplace, a backlash to such investments may seem unreasonable. However, my experience has shown that without exploring all systems, family change may not be long lasting.

CHAPTER 7: CONCLUSION

Use of Self in Therapy

Prior to this practicum experience I was unsure as to what extent the use of self in therapy would play. I found that personality characteristics played a large part in my ability to connect with families. The techniques of EFT required a therapeutic demeanour that was considerate, validating and empathetic. It worked well with my own personal beliefs about working with families.

Beyond the system of the family, Simon (1989) points out that there is a more complex system operating: the family plus therapist. How these two systems combine is what is referred to as "fit". This incorporates elements such as personal style, wisdom, charisma, and resourcefulness. Introducing change into a stuck system can be augmented by these elements. Additionally, fit is not something that is performed, it simply happens. It is non-linear, changing as the therapist changes according to their personal life experiences and according to each different family seen. The families seen during this practicum were in the life cycle stage of families with adolescents. I was not in the same life cycle stage as my families were. I did not have any children and was not married. This may have played an influence in my credibility and power to influence change in the family system. Furthermore, my fit with the family was also influenced by my own adolescent experience with my parents, siblings, and past family rules and expectations that surrounded my notion of adolescence. Other issues that may have influenced the fit between therapist and family include: gender, divorce, death of parent/sibling, and physical disability (Simon, 1989).

The lack of fit between my life cycle stage and the families I saw was not seen as a major drawback. Supervision added another level of fit that helped to rebalance the situation. Changes in the family-therapist system now became the family-therapist-supervision system. This addition is usually a positive influence because it rebalances the situation where fit between therapist and family is unproductive (Simon, 1989). A "trigger family" is defined as a family where the fit between family and therapist is unproductive (McGoldrick, 1982, cited in Simon, 1989). I did encounter one family where I often felt stuck and experienced difficulty. This family had experienced similar experiences to my own family of origin. Working with my supervisor I was able to link my immobilization with this family to my own family history. Part of the work surrounded going back and clarifying issues with my family in order to gain more perspective on the situation. This was very helpful in giving me separation from the client family. At first I was nervous about the similarities to this family, however it was a great opportunity to work on my self as a therapist.

Re-examination of Learning Goals

At the beginning of my practicum experience I was unsure as to the degree that my theoretical knowledge would be heightened by the incorporation of practical, hands-on experience. In regards to my learning goals, I feel that they have all been accomplished. I have learned about the use of my two core theories/interventions (i.e. Bowen Family Systems Theory, EFT) and furthered my knowledge about other theories and interventions. What follows is a brief discussion about my learning experiences.

1. **Increasing knowledge of Bowen Family Systems Theory and incorporating it within the therapeutic intervention.**

Bowen Family Systems Theory is an extremely complex theory for a first time practitioner to incorporate into the therapeutic setting. However, I found that using elements that were integral to the theory, such as genograms, provided a good starting point to understand its application during assessments. As I assessed families from this perspective, my knowledge of Bowen deepened. I read more about the theory, and challenged the theory by relating it to the process and content occurring in family sessions. The only drawback was that due to time constraints, Bowen Family Systems Theory was only used as an assessment tool and not as an intervention tool. However, its application to this population continues to be an interesting area for clinical work.

2. **Increasing knowledge of Emotion Focused Therapy and incorporating it within the therapeutic intervention.**

The application of EFT during this practicum was an exciting and challenging task. The theory itself is derived from attachment theory and was quite familiar to me. However, the application and integration of the intervention in practice was sometimes demanding. For example, the steps involved in EFT were sometimes difficult to follow in practice and were often intertwined to the point where I was unsure at what step I was. Despite this, I found that EFT was congruent with the way I like to work with families. It is a very respectful and appropriate intervention for this population. I believe this was directly related to the techniques of validation and empathetic conjecture which helped to build a strong therapeutic relationship.

The goals of EFT are to "modify family relationships" in order to create a "secure base where children can grown and leave from" (Johnson, 1996, p. 184). From an attachment perspective this goal seems very important to differentiation of self. However,

when the presence of past separations and trauma are also present I wondered how this complicates the process. Is there a certain amount of time when the creation of secure base is no longer a possibility? What is a realistic goal in cases where the primary caregiver has been separated from the adolescent? Can this separation and the subsequent insecure attachment be repaired? Bowlby (1979) discusses how we have internal working models of attachment figures; I wondered to what degree these models could be modified in order to create a more secure view of attachment relationships - in other words, to modify the internal working model from one that includes insecure attachment (i.e. avoidant or ambivalent) to a model of secure attachment.

3. **To learn if an integration of Bowen Family Systems Theory and Emotion Focused Therapy is appropriate for working with troubled adolescents and their families.**

The use of the two main theories that formed this practicum is greatly dependant on the clients. Not all clients responded to each theory in the same way. It is integral that as a social worker we do not fit clients to a theory or intervention, but rather choose interventions that fit clients. This requires that a repertoire of interventions must be developed and constantly updated in order to meet the changing needs of families. What may work with one family may not be appropriate for other families.

4. **Developing and practicing skills to work with and consult within a multidisciplinary setting.**

When I first heard about the opportunity to do my practicum in Child and Adolescent Mental Health at the St. Boniface Hospital I was intrigued. The setting itself is very demanding and there is no shortage of clients. One thing I learned from working

in this setting was how the different perspectives from various professionals (e.g. psychiatrists, psychiatric nurses) fit into a comprehensive model for working with individuals and families. Strengths from all of the disciplines can be incorporated into the perspective of social work practice. For example, psychiatry's extensive knowledge and expectations in diagnosis and medications is extremely useful with clients from the mental health program who require both therapy and medication.

As a setting for this practicum, I was allowed to forward my knowledge of mental health issues, the contribution of family therapy, and the experiences of adolescents and their families. A big part of working within a multidisciplinary setting was learning how to co-ordinate services for families, as well as integrate knowledge from various professional orientations (e.g. Psychiatry, nursing). Many of the families I worked with were also involved with other hospital staff. I made a concerted effort to meet with other team members in order to co-ordinate what the goals for family therapy were with some of the individual and group goals. For example, one of the goals for Family #4 was to decrease the separation between father and daughter, and increase the attachment bond. This would not be possible if the goal for individual therapy was to increase independence from the family. Team members have to be kept abreast about family therapy in order to provide a co-ordinated approach to helping the family.

5. **Increasing knowledge and practical skills to work with families who present with multiple problems and diverse backgrounds (e.g. culturally, economically).**

Each family seen during this practicum provided a different view into family functioning and experiences. No one family had the exact same intervention format or

goals. However, there were similarities in terms of some of the family of origin issues, such as trauma and separations. This experience confirmed my initial thoughts that each family is unique and may require different interventions in order to meet their therapeutic needs.

6. **Increasing knowledge of various theoretical orientations by viewing family therapy led by other professionals.**

One of the values of doing a practicum in a hospital setting is the opportunity to observe therapy by a variety of professionals such as psychiatrists, psychologists, and other social workers. As a new therapist I found this experience to be an important part of my learning experience. It stimulated my thinking on therapeutic techniques and challenged me to incorporate different perspectives and interventions.

7. **Developing confidence in being the primary therapist.**

This goal was the most important and fulfilling learning goals gained through this practicum experience. In the beginning I was unaware of how I would feel being the primary therapist, however, through excellent supervision and accepting clients I quickly developed confidence in my growing abilities. It is difficult to imagine how my confidence would have blossomed without the constant support of my on-site supervisor.

8. **Developing the skills to use theory in order to distinguish between content and process when doing family evaluations.**

One of the most difficult skills to develop was distinguishing between content and process. As a beginning practitioner it is easy to get pulled into the content of what the client is saying. This can sometimes prevent one from attending to the moment-by-moment processes. By developing a personalized technique which was visualizing a

diagram of process, I was able to slow myself down and attend to process. Another helpful tool was to watch the videotapes of the sessions. This allowed me to pinpoint areas where I missed the process and focused more on content. By reviewing the tapes I was able to identify my strengths as well as some areas for improvement.

Conclusion

Preto (1999) said of adolescence, it takes a village to raise a child. This is not a new concept but it clearly sums up the needs of families during this life cycle stage. Approaches that do not look at the family from a systems view may not provide the needed supports that these families require. Building connections to other professionals and working with communities is an essential type of intervention that works to strengthen natural support systems and lessen the isolation that families' experience. Both Bowen Family Systems Theory and EFT provide an effective and interesting approach to meeting the needs of these families. Consideration must be given to the presenting problem(s) and the appropriateness of the intervention to individual families. Similar to any treatment modality used with families, decisions regarding intervention should be client-directed, rather than based on the therapist's preference of intervention.

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Appendices

Appendix A

PARTICIPANT CONSENT FORM

I am a Masters of Social Work student from the Faculty of Social Work at the University of Manitoba. As part of my training I am completing a practicum in Family Therapy in the Child and Adolescent Mental Health Program at the St. Boniface Hospital. By signing this consent you are agreeing to participate in family therapy and that I have explained the practicum to you.

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

Participation in this 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, you will not be refused service from the St. Boniface Hospital.

Information 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 I will be supervised by John R. Smyth and my faculty advisor, Brenda Bacon. In addition, Mr. Smyth is being supervised by a none hospital staff person.

Any questions regarding this practicum may be directed to Dana Bartley (237-2687). Any complaints regarding procedures may be reported to the faculty advisor, Brenda Bacon (474-8454), or John Smyth (237-2684).

Name of Participant	Signature of Participant	Date
Name of Participant	Signature of Participant	Date
Name of Participant	Signature of Participant	Date
Name of Participant	Signature of Participant	Date
Name of Participant	Signature of Participant	Date

Appendix B

Summary Recording

Family name: _____ Beginning date: _____
Worker's name: _____ Termination date: _____
Session number: _____ Date of session: _____
Family Members present:

Goals of session:

Were goals met ?, if not why ?:

Activities/techniques to meet goals:

Identify the pattern:

Theme of the session:

Feelings of each family member:

Practitioner's analysis of session:

Questions or concerns:

Plans for next session:

Appendix C

Post-Intervention Client Questionnaire

Please read each statement carefully and circle your response.

1. Overall I was satisfied with the counselling I received.

Agree	Slightly Agree	Neutral	Slightly Disagree	Disagree
1	2	3	4	5

2. The social worker understood our problems.

Agree	Slightly Agree	Neutral	Slightly Disagree	Disagree
1	2	3	4	5

3. I felt comfortable talking with the social worker.

Agree	Slightly Agree	Neutral	Slightly Disagree	Disagree
1	2	3	4	5

4. What were the most helpful things discussed or done in our sessions together?

5. During our sessions, what did you find to be the least helpful, if anything, to you?

6. What did you learn that is important to you in how you relate to your family or how the entire family relates?

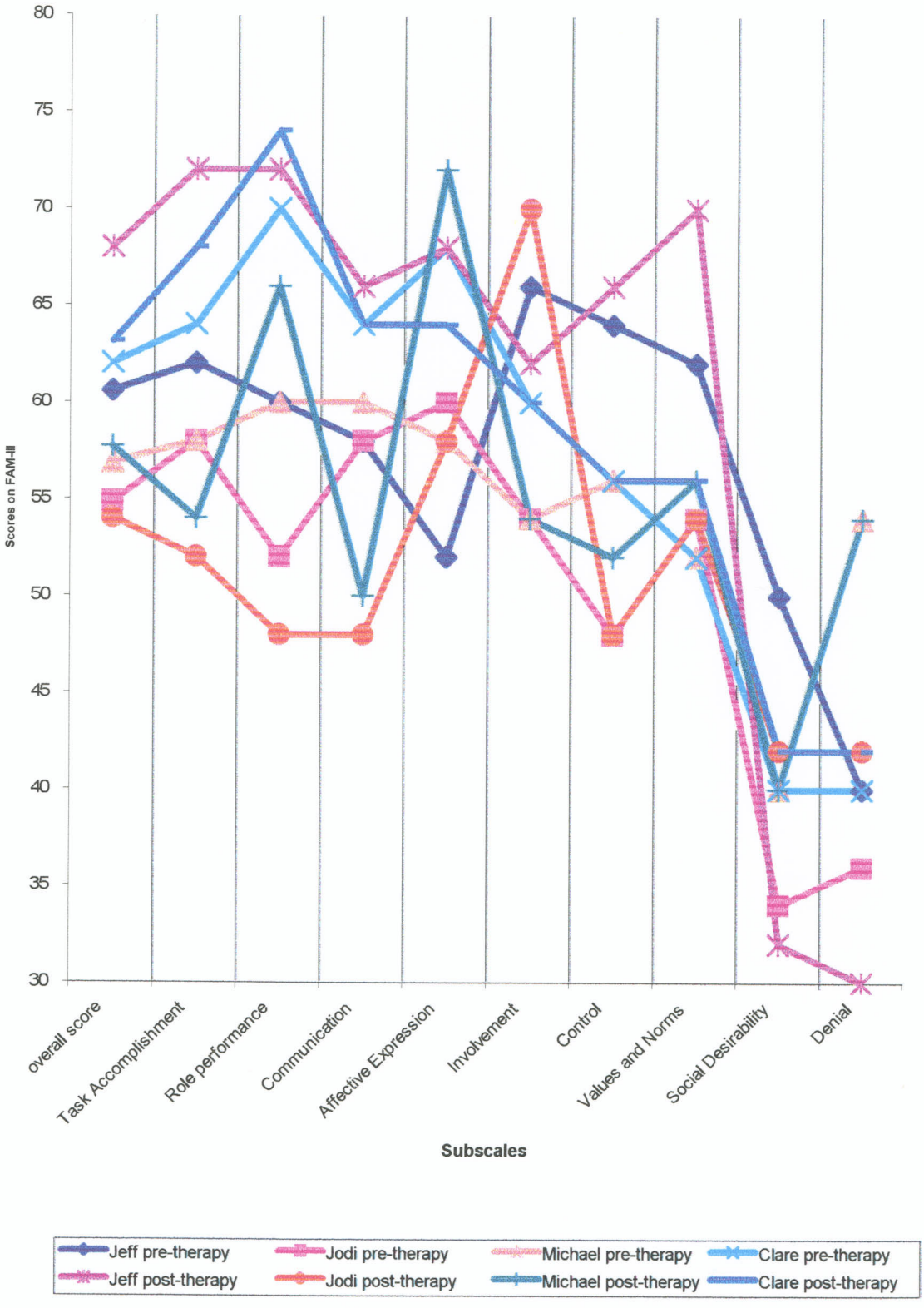
7. What has been the most significant way that therapy has affected your family?

Family #1 FAM-III General Scale

Table 2: Family #1 FAM-III

SUBCALE	Jeff		Jodi		Mike		Clare	
	PRE	POST	PRE	POST	PRE	POST	PRE	POST
TASK ACCOMPLISHMENT	62	72	58	52	58	54	64	68
ROLE PERFORMANCE	60	72	52	48	60	66	70	74
COMMUNICATION	58	66	58	48	60	50	64	64
AFFECTIVE EXPRESSION	52	68	60	58	58	72	68	64
INVOLVEMENT	66	62	54	70	54	54	60	60
CONTROL	64	66	48	48	56	52	56	56
VALUES AND NORMS	62	66	54	48	52	52	52	56
SOCIAL DESIRABILITY	50	32	34	42	40	40	40	42
DEFENSIVENESS	40	30	36	42	54	54	40	42

Figure 6: Family #1 FAM-III

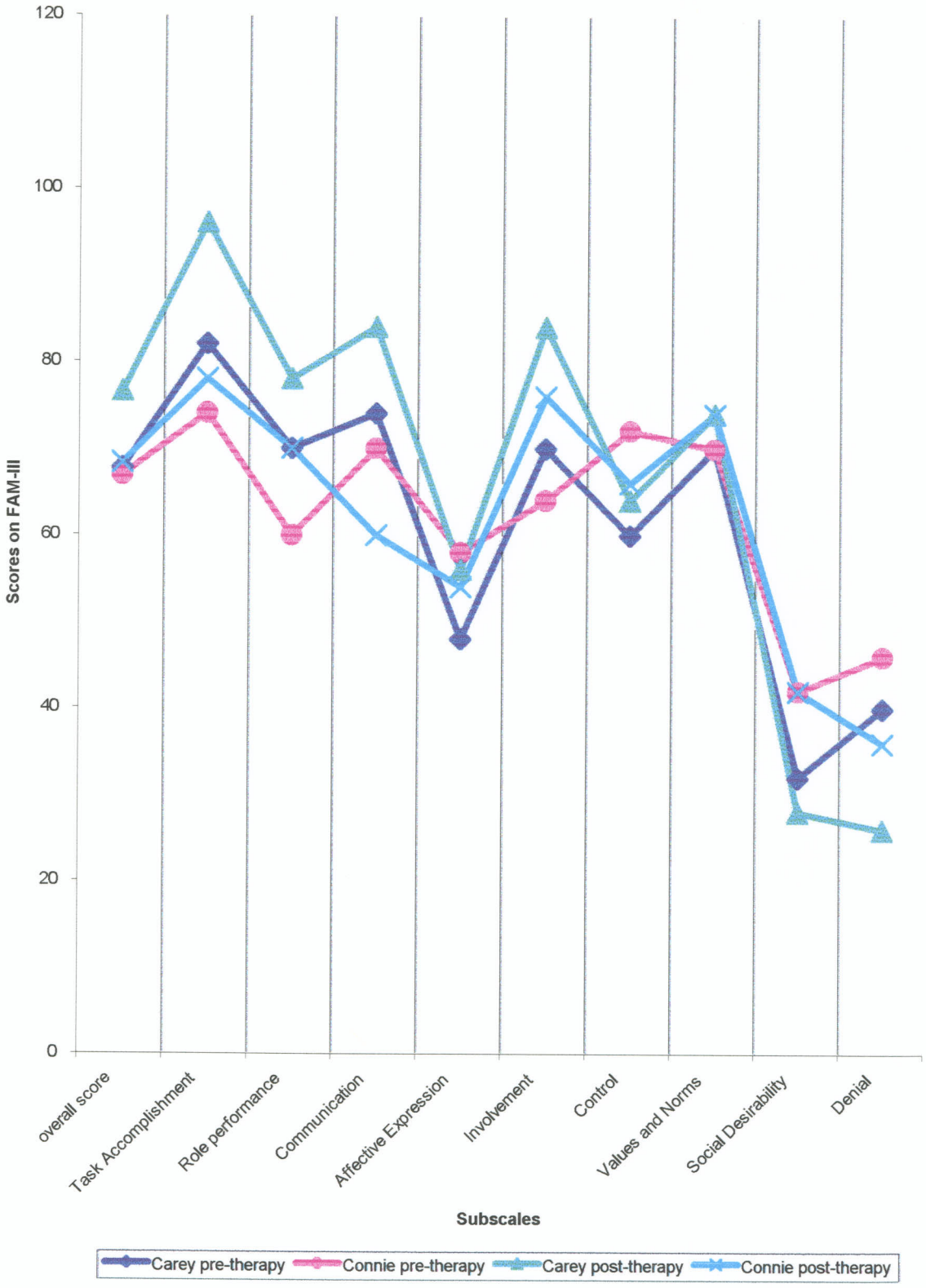


Family #2 FAM-III General Scale

Table 3: Family #2 FAM-III

SUBCALE	Carey		Connie	
	PRE	POST	PRE	POST
TASK ACCOMPLISHMENT	82	96	74	78
ROLE PERFORMANCE	70	78	60	70
COMMUNICATION	74	84	70	60
AFFECTIVE EXPRESSION	48	56	58	54
INVOLVEMENT	70	84	64	76
CONTROL	60	64	72	66
VALUES AND NORMS	70	74	70	74
SOCIAL DESIRABILITY	32	28	42	42
DEFENSIVENESS	40	26	46	36

Figure 7: Family #2 FAM-III

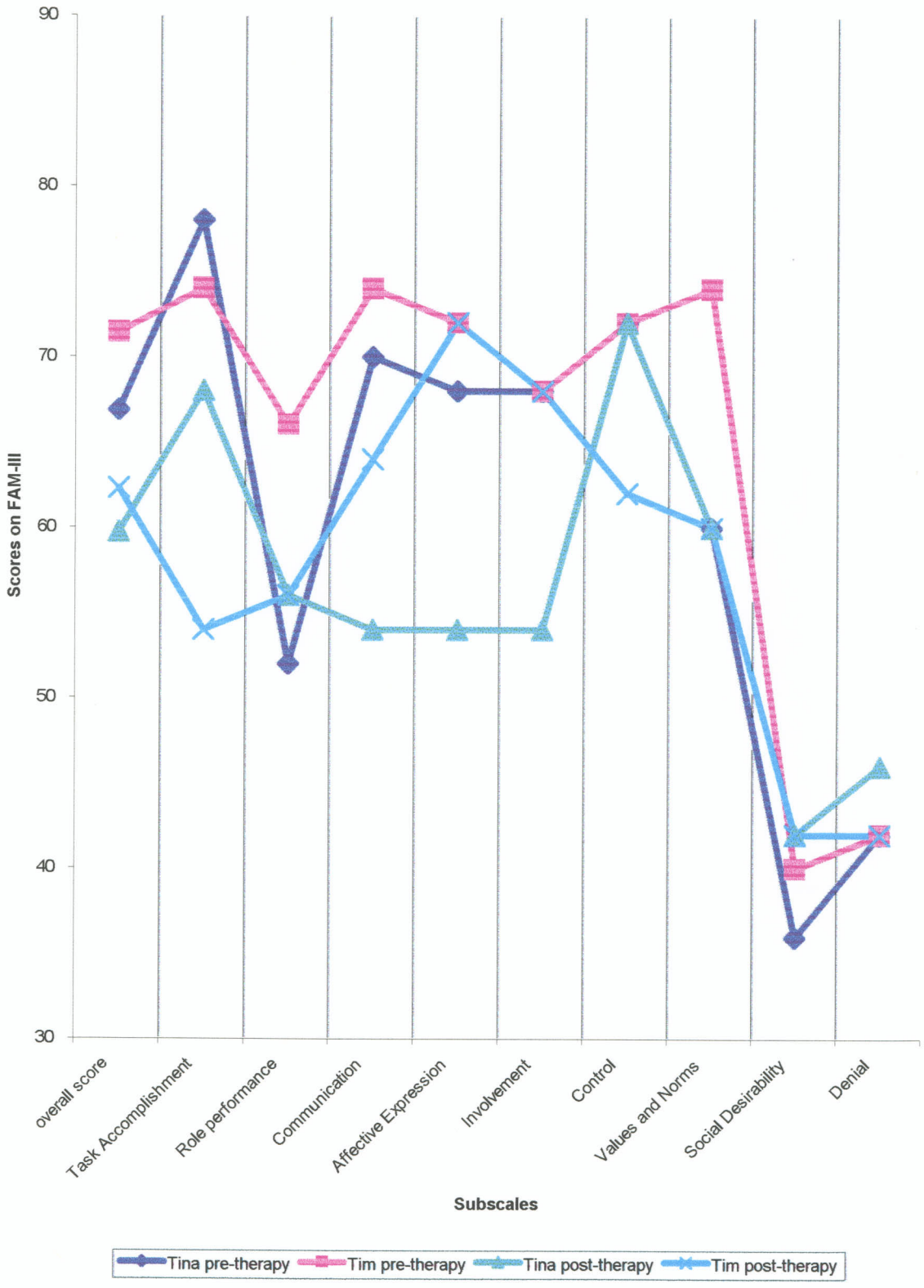


Family #3 FAM-III General Scale

Table 4: Family #3 FAM-III

SUBCALE	Tina		Tim	
	PRE	POST	PRE	POST
TASK ACCOMPLISHMENT	78	68	74	54
ROLE PERFORMANCE	52	56	66	56
COMMUNICATION	70	54	74	64
AFFECTIVE EXPRESSION	68	54	72	72
INVOLVEMENT	68	54	68	68
CONTROL	72	72	72	62
VALUES AND NORMS	60	60	74	60
SOCIAL DESIRABILITY	36	42	40	42
DEFENSIVENESS	42	46	42	42

Figure 8: Family #3 FAM-III

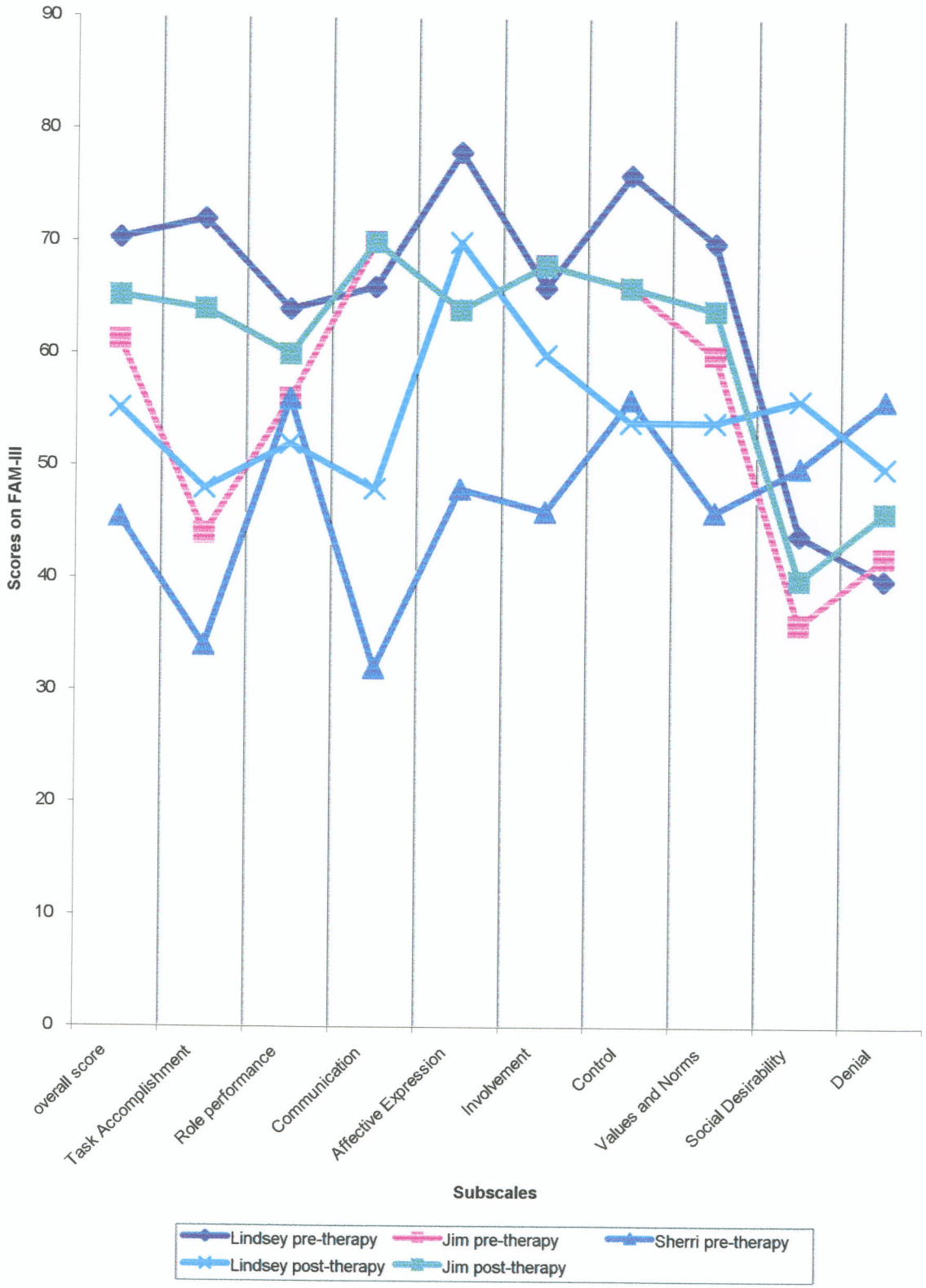


Family #4 FAM-III General Scale

Table 5: Family #4 FAM-III

SUBCALE	Lindsey		Sherri		Jim	
	PRE	POST	PRE	POST	PRE	POST
TASK ACCOMPLISHMENT	72	48	34	N/A	44	64
ROLE PERFORMANCE	64	52	56	N/A	56	60
COMMUNICATION	66	48	32	N/A	70	70
AFFECTIVE EXPRESSION	78	70	48	N/A	64	64
INVOLVEMENT	66	60	46	N/A	68	68
CONTROL	76	54	56	N/A	66	66
VALUES AND NORMS	70	54	46	N/A	60	64
SOCIAL DESIRABILITY	44	56	50	N/A	36	40
DEFENSIVENESS	40	50	56	N/A	42	46

Figure 9: Family #4 FAM-III



Family #5 FAM-III General Scale

Table 6: Family #5 FAM-III

SUBCALE	Stacy		Lisa	
	PRE	POST	PRE	POST
TASK ACCOMPLISHMENT	68	68	74	68
ROLE PERFORMANCE	64	70	48	52
COMMUNICATION	48	62	54	64
AFFECTIVE EXPRESSION	68	60	64	58
INVOLVEMENT	54	70	54	60
CONTROL	56	52	56	52
VALUES AND NORMS	66	62	60	56
SOCIAL DESIRABILITY	44	44	50	42
DEFENSIVENESS	52	50	50	54

Figure 10: Family #5 FAM-III