OPENING THE LENS:

THE TREATMENT OF FAMILIES WITH ADOLESCENTS -

A STRUCTURALLY BASED SOLUTION FOCUSED

FAMILY THERAPY APPROACH

BY

WILLIAM BRODOVSKY

A Practicum Report
Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of

MASTERS OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

ISBN 0-315-76681-6

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Abstract

The practicum explores the use of structurally based solution focused brief therapy with adolescents and their families. The report reviews the developmental phases of the adolescent, the adolescent stage of the family life cycle, and the structural and solution focused models of family therapy.

The model of practice is evaluated through the use of the FAM III general scale, a problem checklist and client feedback. The evaluation instruments support the utility of this interventive method for the target population. Three case examples are provided to illustrate the use of the model, and discuss the results of the evaluation.

Acknowledgements

A number of people were essential for the completion of this report. I would like to thank and acknowledge my partner Libby for her support and endurance. My advisor Harvy Frankel for his guidance and direction. George Enns and Paul Doerksen for their clinical supervision and friendship. And all the families who participated in the practicum and allowed me to learn from them.

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Introduction and Objectives

Aim of Intervention

A structurally based solution focused model of therapy was used to provide treatment to families with adolescents. Treatment was offered on the assumption that symptom development or problems are not an indication of family dysfunction. Families are seen as "stuck" or "derailed" as opposed to "pathological" or "dysfunctional". The problem can be understood as either a family's difficulty negotiating the transition to the next stage of the family life cycle, or as the result of a limited world view and problem definition based on past experiences and/or difficulties.

A structural framework was used to identify the family structures blocking transition and/or the resolution of the problem. A solution focused interventive strategy was employed to highlight and enhance behaviours that lead to solutions regarding the presenting problem and the developmental impasse.

Educational Benefits to the Student

This writer received formal training in family therapy with adolescents and their families. The educational goals of this practicum were the following;

a) To develop greater experience and skills relating to families with adolescents.

b) To develop and enhance assessment skills from a systemic perspective and structural framework.

c) To develop interviewing and intervention skills in solution focused family therapy.

d) To develop a greater knowledge of systemic thinking, and the models of structural and solution focused brief therapy.

e) To develop and integrate a conceptual model that can serve as a foundation for future development as a family therapist.

Introduction

> "Say the magic word "adolescents" to most adults and you're likely to get a litany of complaints: They spend all of their time in front of the tube or playing video games. They lack ambition and they won't read. They want instant gratification. They have no values, no interest" (Hersch, 1990, pp.21).

Adolescence is a time like no other in the life cycle of both the individual and the family. The developmental changes that begin in adolescence are profound as they represent changes in status and function, and occur at a biological, psychological, and social level. As a result of these developments, every member of the family must undergo a major shift in their role and the expectations placed on them by others. Because so much is happening so fast, adolescents, parents, and other family members are often not sure how to relate to each other, and deal with new situations. Families can easily become stuck at this point in the life cycle. The identification of a problem with adolescents is often an indication that the family is having difficulty adjusting to this new stage of development.

By the time a family with an adolescent calls for assistance the identified problem has often reached the family's breaking point. Parents feel that nothing they have

tried has worked and that if something isn't done soon it will be too late. The majority of families have already attempted to solve their problem, and failed. Often there are feelings of hopelessness and despair. Adolescence challenges parental competence at the best of times. Seeking therapy may add to the perception of incompetence.

In order for a therapist to intervene effectively he or she must have an understanding of the elements that directly or indirectly have led to the development and maintenance of what the family considers a problem. The advantage of a systemic perspective is that it incorporates a view which includes the individual in the context of the family, existing in society. Families identifying an adolescent as the presenting problem requires an understanding by the therapist of the developmental stage of adolescence, and of the family with adolescence.

Both structural and solution focused models have proven to be effective in clinical situations concerning families with adolescents (Fishman, 1988, Berg & Gallagher, 1989). Social workers, and other clinicians have an ethical imperative to provide effective and efficient treatment. Sluzki (1983) has suggested that there is an advantage to utilizing more than one model. He notes that,

"...the same paradigmatic frame does not reduce the

requirement that conceptual consistency within models should be maintained. By means of defining their common systemic base, however, it vastly expands the repertoire of conceptual and technical tools of the family researcher, trainer, and therapist, as it empowers them with the choice within a wide range of mutually potentiating family variables, hypotheses, and interventions" (pp. 475).

The literature review of this report will be divided into two sections. The first will review the literature concerning the life cycle of both the individual adolescent, and the family at that stage. Although the life cycle perspectives provide some understanding as to why problems might be occurring, they do not provide for an interventive strategy. The second section will review the conceptual assumptions of both the structural and solution focused family therapy approaches as interventive models. It is believed that the utilization of both provides for a more effective delivery of service.

Chapter 1 - Developmental Models of Adolescence

A Brief History of the Development of Adolescence

Adolescence, as a stage of development between childhood and adulthood was first conceptualized in the last two decades of the nineteenth century (Aries, 1962). Up until the industrial revolution, the family functioned as a comprehensive economic unit. The home was the centre for work, and children were expected to share the tasks of the adults and contribute to the economic maintenance of the family. "Childhood was a brief preparatory period terminated by apprenticeship and the commencement of work, generally before puberty" (Hareven, 1982, pp. 451).

Industrialization and urbanization created a change in both the family's role and it's function. Families and their homes were no longer a work unit. Economic activity became limited to consumption and childcare (Hareven, 1982). The role of the family became specialized to childbearing, child care and socialization. The change in the economic expectations of children and adults marked an increasing separation between childhood and adulthood, thereby prolonging the transition into adulthood (Preto & Travis, 1985). G. Stanley Hall's (1904) identification of adolescence as a separate stage was an attempt to understand this development,

and the tasks, experiences and transitions which were being encountered by these not quite adults.

Hall's (1904) initial conceptualization saw adolescence as a time of "great storm and stress". This has remained the popular perception (Kendal & Williams, 1986, Offer & Sabshin, 1984a). Although there is some debate regarding the nature of the adolescent stage of development, there is considerable consensus regarding the changes which occur during this stage. The next section will provide an overview of the changes and tasks which occur during this phase of the life cycle.

The Adolescent Phase of the Life Cycle - Coping With Sexuality, Identity Formation, & Autonomy

Adolescence as defined by Blos (1979) is a time of conflict and turmoil instigated by the psychological process and adaptation to puberty. Erickson (1968) sees it as a normative crisis and a time of strain between the individual and society during which one's identity is formed. Pittman (1987), calls it a time of normal psychosis. While Offer & Sabshin (1984a) understand it as a transitional stage comparable to other stages such as retirement or menopause. Adolescence can be a time of significant psychological, physical, and social change and development (Steinberg, 1987). Offer & Sabshin (1984a) note that 80% of middle class high

school students make the transition into and through adolescence without turmoil or major symptoms. With or without turmoil, adolescence is a time of developing independence, and movement away from the family. For both the adolescent and their parents this can be stressful as new behaviours and patterns of interaction must be developed in response to the adolescence increasing independence and maturity.

The uniqueness of adolescence is a result of the developmental changes that occur and their cumulative effect on the individual. Initially adolescence is marked by rapid physical growth and sexual maturation. These tangible changes begin the negotiation of the major developmental tasks; coping with sexuality, identity formation, and autonomy (Erickson, 1968).

The physical maturation that begins in adolescence is often the first sign of the changes to come. "The only other time in the human life cycle when there is as much physical growth and change as that which occurs during adolescence is during the fetal and neonatal stages" (Kendall & Williams, 1986, pp. 525). The major difference is that the adolescent is aware and able to observe these changes. Puberty not only transforms the physical self, but heralds the initiation of the psychological transition to adulthood (Preto, 1988). The

period is highlighted by the physical development and maturation of the reproductive organs, and secondary sex characteristics. "The greater size, growth of body hair, voice changes, and other manifestations of growing reproductive capacity all send strong signals to the adolescent, to his or her parents, and to the immediate society, that the young person is becoming an adult" (Kidwell, Fischer, Dunham, & Baranowski, 1988, pp. 76).

Accompanying the physical and behaviourial changes is an increase in sexual thoughts and feelings. Family members may experience confusion and fear when faced with the budding sexuality of their adolescent (Preto, 1988). The parent's perception of these changes can be of greater significance than the adolescent's own perceptions (Steinberg,1987). Parents who are comfortable with their own sexuality may be better able to set reasonable limits on the expression of sexual feelings. The adolescent is able to obtain the information he or she requires within a setting which promotes the development of acceptable forms for sexual expression. When sexuality is denied, ignored, or otherwise blocked by the parents, it may become much more difficult to develop a positive sexual self concept. "The probability of increased feelings of alienation between adolescents and their parents

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

The importance of these physical changes cannot be overstated. Because the physical growth is asynchronous, different parts of the adolescent's body exhibit rapid growth at different times (Kendall & Williams, 1986). This often leads to feelings of awkwardness or "gawkiness" being both felt and displayed by the adolescent. Physical growth does not necessarily signify maturation in other areas. Thus, it is not uncommon for others to expect psychological and cognitive abilities that are beyond the adolescent's capabilities. Offer and Sabshin (1984a) suggest that... "the biological apparatus has to function smoothly before the individual can mature psychosocially" (pp. 82). The timing of these events can be crucial to the adolescent's successful negotiation of the additional developmental tasks.

Accompanying the physiological growth are transformations in the cognitive abilities of the maturing adolescent. According to Inhelder & Piaget (cited in Kidwell, et.al., 1988) three interrelated activities are required for an individual's cognitive and social development: reflection, decentering, and the ability to take on the role of others. Reflection, the ability to think about thinking allows the

adolescent to begin to observe their own thoughts in addition to ensuring they are taking into account the interrelation of other aspects of a particular problem or situation. The ability to communicate their own reasoning compels decentering, observing the problem or situation from another perspective outside of the self. Accordingly, decentering requires the adolescent to take on the role of another. These developing abilities allow the adolescent to begin to reason like an adult, and accomplish what are called formal operations. According to Kidwell, et.al. (1988),

> "Formal operational thinking allows the individual to think in terms of symbols - to think about and reflect upon his or her own mental status. The adolescent also acquires the ability to recognize possibilities as well as actualities and to construct ideals which are not tied to the concrete world of here - and - now. Thus the adolescent can mentally solve abstract, propositional, "as if" problems which younger children either ignore or are incapable of solving" (pp.77).

These new found capabilities allow the adolescent to begin to develop a sense of self based "mature cognitive and social cognitive abilities" (Cooper, Grotevant & Condon, 1983). The ability to consider the abstract while examining and observing the self allows the adolescent to experiment with new ideas and beliefs and to develop their own individual

identity (Offer & Sabshin, 1984a, Kidwell et al, 1988, Kendall & Williams 1986, Steinberg, 1987).

"The development of an identity is almost universally believed to be a psychological task of adolescence" (Kendall & Williams, 1986). Identity refers to one's own personal perception of those attributes, characteristics and qualities that best portray them. "This self structure undergoes its greatest transformation during adolescence, when it seems to become more abstract and psychologically oriented" (Preto, 1988, pp. 260). Much of our understanding of this process is based on the work of Erickson (1968) who classifies adolescence as the time of identity crisis. He defines it as a pivotal direction and perspective that each youth must determine and develop for themselves, and as a time and source of strain and tension between the individual and society. Kidwell et.al. (1988) note that, "developmental influences that contribute to the perception of oneself as distinct from others and as a reasonable consistent and continuous "whole" person contribute to a sense of ego identity" (pp. 79).

The formation of one's own ideas and beliefs is central to the development of an identity. The search for identity is seen in the various roles, attitudes, and beliefs that adolescents often experiment with. These can include occupational goals, political and religious beliefs, and

sexual identity. "The process of identity formation in each area involves two aspects: exploration - active consideration of alternative possibilities - and commitment - certainty of decision" (Cooper et al, 1983, pp. 46). This is often a source of discomfort for many adults, as the adolescent takes hold of each new idea with an idealistic fervour.

The adolescent's ability to critically observe their world also allows them to perceive the faults and strengths of the adults in their lives. The development of their own identity calls for the personal integration of those attributes which are admired or seen as positive, and the rejection of those perceived as negative (Preto & Travis, 1985). Adolescents fear a loss of self if they unconditionally accept another's beliefs or lifestyle. Yet at the same time, they may look for models which they can follow and incorporate as their own. The search for identity often leads adolescents to disagree with their parents and is a primary source of conflict between the adolescent and their family (Fishman 1988, Preto, 1988). The adolescent's newly discovered "advanced reasoning abilities" can make it almost impossible for the parent to employ the unquestionable authority they previously had over the young child. "What is often construed as back-talk may actually have little to do with the adolescents' feelings toward their parents and have

more to do with their desire to exercise new intellectual skills" (Steinberg 1987, pp. 83).

The physical maturation of the body and the accompanying cognitive developments clearly place the individual adolescent apart from other younger children or siblings. The formation of an identity allows the adolescent to begin ... "to sever childish dependencies on parents while taking responsibility for his or her own behaviour, and forms an individuated sense of self - a sense of oneself as a self-governing, separate individual" (Silverberg & Steinberg, 1987, pp. 295).

Adolescence is the time when one begins to venture out into the world, on one's own. A common complaint about adolescents is that they are never home, and when they are, they are never interested in spending time with the family. Reliance on parents and the family diminish as peers become increasingly important, both for support and confirmation of self (Preto, 1988). Blos (1979) has characterized this process as individuation. Resolution of this developmental task requires the adolescent to become emotionally autonomous from his or her parents. This is perhaps best described as the adolescent's discovery that his or her parents are people, and the loss of the idealized image he or she may have developed during childhood (Silverberg & Steinberg, 1987).

Autonomy requires that the individual begin to make decisions for him or herself, which functions to prepare the adolescent for his or her launch into adult life. This is not a smooth or continuous process. The struggle for autonomy requires the adolescent to let go of the support, security, and safety of childhood (Preto & Travis, 1985). Blos (1979) sees it as an oscillating dynamic, moving back and forth between dependency and independence. This can be quite confusing for family members as they try to dance back and forth between the varying needs and desires of the adolescent.

This oscillation can be exacerbated depending on the parents' perception on their changing role. The transition into adolescence foreshadows a loss for the family, particularly for the parents who must shift to a reduced caretaking role for their adolescent. "Autonomy does not mean disconnecting emotionally from parents, but it does mean that an individual is no longer as psychologically dependent on parents and has more control of making decisions about his or her life" (Preto, 1988, pp. 262).

Summary and Comments

The successful resolution of the tasks relating to sexuality, identity, and autonomy allow an adolescent to enter into the young adult stage, and essentially leave the family. When an adolescent begins to display problematic behaviour it is enticing to simply identify the developmental task, and to develop an interventive strategy that focuses on the adolescent and the resolution of the specific task. A common criticism of the developmental model of adolescence is that one cannot view the individual without examining the context he or she exists in.

One must also take into account the many normative assumptions that are inherent in the developmental model of adolescence. The model is based on the white middle class male living in North America (Gilligan 1982). Hines (1988) and Fulmer (1988), both note the impact and effect of socio-economic status in relation to development, whereas Offer and Sabshin (1984b) identify differences based on cultural norms and values. The impact of these normative assumptions can be most extensively seen when one considers gender.

According to Gilligan (1982), the traditional developmental model has recognized what are considered male tasks, and has devalued or ignored the differences that exist between male and females. She notes that "the quality of

embeddedness in social interaction and personal relationships that characterizes women's lives in contrast to men's, however, becomes not only a descriptive difference but also a developmental liability when the milestones of childhood and adolescent development in the psychological literature are markers of increasing separation" (pp. 9). Gilligan (1982) does not believe that the formation of identity and the development of autonomy are relevant developmental tasks to females. Rather she sees them as "favoring the separateness of the individual self over connection to others, and leaning more toward an autonomous life of work than toward the interdependence of love and care" (Gilligan, 1982, pp. 17). In her thorough critique of the developmental model Gilligan (1982) illustrates the importance of attachment in the life and development of women, and how it differs from the traditional view. The orientation of the model towards a life of work and independence does not fit well with the experience and development of the female adolescent.

Given these limitations, one must be careful not to place too great an emphasis on the resolution of developmental tasks. An adolescent also exists in a context that includes his or her family, community, culture, socio-economic status, and gender. While the adolescent is for the first time able to begin to make his or her own way in society, his or her development is embedded in the family structure (Preto &

Travis, 1985). The resolution of the developmental tasks for the most part occur within the framework of the family. Therefore one must also understand the context which the resolution of these tasks occur in.

The Family Life Cycle

The concept of normative processes has a long tradition in the field of sociology as can be seen in the normative role structures of the family developed by Talcott Parsons (Hoffman, 1990). Mattessich and Hill (1987) note that "...scholars working on the family development perspective have intentionally and unashamedly assimilated concepts from other disciplines in order to tailor-make a relevant framework for analyzing the process of family change" (pp.437). This seems to have been the case in the field of family therapy. The concept of the family life cycle was first introduced to family therapists almost twenty years ago by Haley (1973) and Solomon (1973). The continuing development and acceptance of the family life cycle model has had a significant, if not major impact on how family functioning is understood by family therapists (Breunlin, 1983). Prior to the development of the model, symptoms and dysfunctional patterns were perceived as an indication of family pathology. The function of therapy was to correct and "cure" the pathology. The family life cycle provides an alternative perspective that "...views

symptoms and dysfunctions in relation to normal functioning over time and views therapy as helping reestablish the family's developmental momentum" (Carter & McGoldrick, 1988, pp. 4).

The life cycle model views families moving forward in time, passing through predictable life stages. Each stage requires the family to develop new methods and modify it's structure in order to meet the needs of the changing family (Koman & Stechler, 1985). Carter and McGoldrick (1982, 1988) propose that the life cycle can be broken down into six stages; the unattached adult, the new couple, families with young children, families with adolescents, launching children, and the family in later life. Each stage has a central emotional process that must be successfully negotiated in order for the family to make the transition to the next stage. The process involves "...the expansion, contraction, and realignment of the relationship system to support the entry, exit, and development of family members in a functional way" (Carter & McGoldrick, 1982, pp. 175). Its first premise is that "the symptom is a signal that a family has difficulty getting past a stage of the life cycle" (Haley, 1973, pp. 42). The significance of the family life cycle approach is its applicability to the various schools of therapy. According to Liddle & Saba (1983), "it is a template that transcends theoretical allegiance" (p 162).

The linking of family problems to transitions in the family life cycle requires that a therapist have an understanding of the transitional process. Carter and McGoldrick (1982) state that it is "useful to conceptualize life cycle transitions as requiring second-order change, or change of the system itself" (pp. 175). They note that the resolution of problems can often be accomplished by the incremental rearrangement of the system (first order change). However second order changes in relationship status are necessary to accomplish the tasks of the stage in question.

According to Hoffman (1988), a successful transition is made through a discontinuous change process which involves a leap to a new level of family organization. The history of the transformation is as follows:

> "First the patterns that have kept the system in a steady state relative to its environment begin to work badly. New conditions arise for which these patterns were not designed. Ad hoc solutions are tried, and sometimes work, but usually have to be abandoned. Irritation grows over small but persisting difficulties. The accumulation of dissonance eventually force the entire system over an edge, into a state of crisis, as the homeostatic tendency brings on ever-intensifying corrective sweeps that get out of control. The end point of what cybernetic engineers call a "runaway" is either that the system

breaks down, that it creates a new way to monitor the same homeostasis, or that it spontaneously takes a leap to an integration that will deal better with the changed field" (Hoffman, 1988 pp. 93-94, 1981 pp. 160).

The discontinuous model of change is based on the ideas of second order change (Breunlin, 1983), and appears to accurately depict family behaviour during a transition. However there are a number of criticisms which have been made regarding it. Breunlin (1983) notes that the literature based on this model places a heavy emphasis on paradoxical strategies and other sophisticated interventions designed to produce dramatic outcomes. Liddle and Saba (1983) offer more specific shortcomings. In particular they are suspicious of a description which "creates the illusion of specificity (Whiteheads's fallacy of misplaced concreteness) regarding the timing of change" (pp. 168). In so doing the model ignores less spectacular transformations and changes which might have precluded the "leap". They also call into question the "all or nothing" view that the model fosters to the exclusion of other validated concepts.

In the final analysis, it is quite likely that both the models of change can occur. As Liddle and Saba (1983) suggest, "it seems wisest to consider a number of interlocking

factors in addressing the process of developmental and clinical change" (pp. 170).

Before addressing the life cycle of the family with adolescents it would be prudent to mention a number of cautions which must be kept mind when considering the family life cycle perspective. Carter and McGoldrick (1988) caution that a rigid adherence to the ideas of what is "normal" can be damaging in that they foster the belief that any deviations are pathological. Secondly, they believe placing too great an emphasis on the uniqueness of a family and the changing world ignores the historical context the family developed and exists in. The family life cycle concept is useful for understanding, assessing, and occasionally reframing a family's problem (Liddle & Saba, 1983). However, the model for the most part details the statistically valid experience of a traditional, two parent, middle class, white family, in North America (Carter & McGoldrick, 1988). The impact of single parent and remarried families, cultural variables, gender and the changing role of women, and economic realities must all be taken into account as well. The context in which the family is embedded should be given priority. At the same time one must also take into account an understanding of the individual developmental stages of each family members without losing sight of the relationships, interconnections and influences each has on the others (Liddle & Saba, 1983). To

disregard any these is to neglect the true value of the system based perspective and can be considered a limited perspective.

The Family with Adolescents

In this stage the family undergoes a transformation from a system that nurtures and protects its young children to one that attempts to prepare the maturing adolescent to take on the responsibilities of an adult. Because this stage often coincides with changes in the parents as they approach middle age, and grandparents entering old age, the transition requires alterations in relationships across generational boundaries (Carter & McGoldrick, 1982, Preto, 1988). The major emotional task to be negotiated involves increasing the flexibility of the boundaries around the family in order to allow for the children's independence (Carter & McGoldrick, 1982). Second order changes in family status include; changes in parent - child relationships in order to allow the adolescent to move in and out of the family system, and a refocusing for the parents on the issues of career and their marriage (Carter & McGoldrick, 1982).

The primary task of increasing the flexibility of the boundaries around and within the family primarily involve the issues of autonomy, responsibility, and control, while

maintaining basic issues of trustworthiness (Karpel & Strauss, 1983). One of the first signs of approaching adolescence can be an increasing desire for privacy on the part of the child. Bedroom doors remain closed, and sharing a room with a younger sibling can lead to chronic complaints about the lack of privacy. This withdrawal from the family is accompanied by a move towards peers and the outside world (Carter & McGoldrick, 1982). For parents this also marks the time when they can no longer maintain complete authority. This can often lead to feelings of powerlessness on the part of the parents, and challenges parental competence (Kidwell et.al.1983, Preto, 1988, Silverberg & Steinberg, 1987).

The relaxation of parental authority is often the central issue of parent adolescent conflict. "Flexible boundaries that allow adolescents to move in and be dependent at times when they cannot handle things alone, and to move out and experiment with increasing degrees of independence when they are ready, put special strains on all family members in their new status with one another" (Carter & McGoldrick, 1982, pp.183). The flexibility required is essential for the adolescent's development of his or her own identity, as it allows them to begin to explore the world outside the family. This can also lead to family members thinking that the integrity of the family is compromised (Preto & Travis, 1985).

Adolescence can be considered one of the more difficult periods for the parents. Silverberg and Steinberg (1987) report that parental stress is higher, and that parents feel least adequate and competent, especially regarding autonomy and discipline. According to Carter and McGoldrick (1982), "families that become derailed at this stage are frequently stuck in an earlier view of their children" (pp.183). Accepting the adolescent's coming of age also requires an understanding that the parent has ceased to be the central figure in their child's life. Not only are parents less likely to derive the same pleasure and enjoyment they previously had in the child's younger years, they also have to come to terms with their child's imminent departure, and their own aging. "By far the most common and the most significant issue presented to the parents by the advent of adolescence is the loss of the child" (Karpel & Stauss, 1983, pp.61).

While the adolescent must struggle with the developmental tasks of identity, sexuality, and autonomy, parents may encounter their own struggles regarding the reassessment of their lives. In particular parents often must reevaluate their marriage, careers, and the move into a mid life stage (Carter & McGoldrick, 1982, Kidwell et. al., 1983, Preto & Travis, 1985). "While middle adulthood is not a period of psychological upheaval and dramatic crisis for most

individuals, these years may be a time of stress, diminished marital satisfaction, life reappraisal, and increased introspection about the physical and psychological self for many adult" (Silverberg & Steinberg, 1987, pp.294).

This can be a source of stress in the family as the parents must come to terms with their unrealized dreams and ambitions and their change in physical appearance. Career changes, separations, and divorce can often occur at this time (Preto & Travis, 1985). An adolescent beginning to plan for their career, and becoming a sexual being can fly in the face of a parent's feelings of disappointment or dissatisfaction with these same issues(Kidwell et. al., 1983). The additional stress of an adolescent questioning authority, challenging and arguing against family rules, becoming sexual, withdrawing from the family, and generally shattering the stability a family with younger children can lead to the adolescent becoming identified as the problem from the perspective of a parent.

Silverberg and Steinberg (1987), who investigated the relationship between parents and their adolescents concluded that,

> "it is not clear whether youngsters' level of emotional autonomy and parent-adolescent conflict affect parents' sense of self and well-being, or alternatively, whether

parents' level of well-being and experience of midlife identity concerns contribute to the intensity of conflict in their relations with their children and to their youngsters' increasing emotional autonomy" (pp. 310).

Summary and Comments

It is clear that there are parallels between the developmental tasks the parents and adolescents, and that the renegotiation of the relationship between the two transforms the family structure. During the transition the family can experience significant stress as the system is in disequilibrium, and a significant amount conflict may be apparent (Carter & McGoldrick, 1982, Kidwell et. al., 1983, Preto & Travis, 1985). Kidwell et al (1983) believe that all families with adolescents experience varying degrees of stress as a result of this "normative life stage developmental event". Steinberg (1987) notes that it is easy to mistake disequilibrium for conflict. It is essential that therapist be aware of the developmental stage of the family and the individuals members, and address the many ways parents and their adolescents may be struggling with similar concerns regarding personal goals, relationships, and the issues of autonomy and identity (Preto & Travis, 1985).

Approximately 20% of adolescents and their parents do have serious difficulty in their relationship with each other (Offer & Sabshin, 1984a), while another 20% have periodic conflict and other relational difficulties (Silverberg & Steinberg, 1987). While a therapist must be aware of the developmental stages and stresses they must also be careful not to minimize nor ignore dysfunctional patterns which can and do occur. Problems can also occur as a result of unresolved conflicts between parents, experiences of abuse by the parent or adolescent, chemical dependency, and disability are but a few of the possible influences a family might also experience. Whether a family is experiencing a developmental impasse or a more serious problem is a major question to be assessed. Nevertheless the majority of families experiencing difficulties with their adolescents are not necessarily dysfunctional. Families entering therapy have made attempts to solve their problems and not been successful. They are however stuck, and unable to evolve or develop a new method of interaction and behavior which successfully resolves the problem.

The family life cycle model offers a powerful conceptual understanding and explanation of the predictable stages of family life. In addition it can direct interventive strategies, through the awareness of normal family functioning. However, the life cycle model does not provide

a method of therapy. Rather it allows and assists the majority of perspectives to become more complex in their understanding (Liddle & Saba, 1983).

Chapter 2 - Clinical Models of Intervention

Introduction

> "The dialectical, ecological, and dynamic-interactional perspectives suggest that critical periods for the family are those which are characterized by fundamental, rapid and/or dramatic change in individual family members. Such periods are critical because the system must adjust to new competencies and concerns of its members; especially critical are those times during which a number of individuals are changing simultaneously. Adolescence, because it is a time of profound change in the child and in the child's parents, is one such critical period." (Steinberg, 1987 pp. 81)

When a family presents with an adolescent as the identified problem, the therapist or the service delivery system is requested to help solve the problem. Although the problem can be understood in a number of ways, primarily it is seen from one of two perspectives. The problem can be seen as the adolescent, and from an intrapsychic perspective he or she may be experiencing difficulty resolving the developmental tasks. From such a perspective the adolescent could be offered individual therapy in order to assist in resolving these issues. This often appeals to the family as it supports their view of the problem, and it is a simpler and less

overwhelming process than meeting with the whole family and facing the conflict, anger, and tension often present when adolescents act out.

If one chooses to view the problem from a family systems perspective one then sees the adolescent, and the problem, as a symptom of a family experiencing stress. From this perspective one can incorporate an understanding of adolescent development, as well as the developmental stages of each individual family member. However this is understood within the context of the family's life cycle stage, and the family's transactional pattern. The therapist can then assess whether the family is experiencing a normative crisis or problem in the sense that they are either having difficulty making a transition to a new stage of development, or that family development is blocked.

Breunlin et.al. (1988) claim that evidence of the increasing effectiveness and acceptance of treating adolescent problems with family therapy can be seen in the proliferation of articles and studies that have published over the last ten years. Hall (1984) and Jansen (1986) report that the effectiveness of a family systems approach to be of equal or greater effectiveness than individual treatment. While Kelly et. al. (1989) specifically comment on the greater effectiveness of a systemic family therapy approach regarding

acting out behaviour problems in adolescents. Breunlin et.al. (1988) conclude that "there is also growing evidence that single model approaches to adolescents may be less desirable than approaches that combine the strengths of several models in an integrated or carefully eclectic fashion" (pp.327).

The individual, family and social contexts and the interrelationship between them are taken into account by structural family therapy (Aponte & Van Deusen, 1981). The role of the therapist is to assess why the family is not functioning adequately, and to assist the family through active intervention. Simply put the therapist identifies the underlying structure that supports the problem and develops a solution to that problem.

The underlying assumption of the structural and most other models of therapy is that identifying the problem is essential to determining the solution. It has been suggested, however, that solutions can be developed by increasing non-problematic patterns as opposed to changing the problematic pattern (de Shazer & Berg, 1988). This approach, rather than trying to fix what is not working, aims to improve on what already is. Solution focused brief therapy "utilizes what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves" (de Shazer et. al., 1986, pp. 208).

This practicum examined the treatment of families with acting out adolescents from a family systems perspective. An assessment model based on Minuchin's (1974) structural family therapy was employed in order to provide map of how the family functioned. Interventive strategies were based on the solution focused brief therapy model as developed by de Shazer and the Milwaukee Brief Family Treatment Center (de Shazer, 1988). Specifically, treatment addressed what the family was doing that was already working, based on an assessment of the family structures that were already functioning effectively.

It should be noted that the solution focused approach falls under the category of strategic family therapy (Fish & Piercy, 1987, Rosenbaum, 1990). This practicum employs a model of family therapy which utilizes both structural, and strategic frameworks. At present, there is mixed reaction in the field as to whether or not it is wise to integrate the two (Fish & Piercy, 1987). However, theoreticians agree that at minimum, any attempts to integrate the two must include a clear understanding of the assumptions and the conceptual basis of each approach (de Shazer, 1984b, Sluzki, 1983, Stanton, 1981). An overview of both the structural and solution focused models will be presented in order to clarify the conceptual orientation each holds.

The Structural Model

According to a survey of leading structural therapists, the structural model, is based on

> "...the theoretical assumption that families are evolving, hierarchical organizations, with rules, or transactional patterns for interacting across and within subsystems. ...symptomatic behaviour is maintained by an inadequate hierarchy and boundaries, and improving a family's organization will change not only the symptomatic behavior, but the individuals who are part of that organization" (Fish & Piercy, 1987, pp.122).

The structural model is based on the work of Salvador Minuchin, and is best represented in his book "Families and Family Therapy" (1974). Structural family therapy is;
"a body of theory and techniques that approaches the individual is his social context. Therapy based on this framework is directed toward changing the organization of the family. When the structure of the family group is transformed, the positions of members in that group are altered accordingly. As a result, each individual's experiences change" (pp.2). The model emphasizes that both family functioning and the well being of the individual family members are related to how the family is organized (Walsh, 1982).

The structural model begins with the view that the presence of a problem does not differentiate a normal family from an abnormal one. According to Minuchin (1974) in a ordinary family, "...the couple has many problems relating to one another, bringing up children, dealing with in-laws and coping with the outside world. Like all normal families, they are constantly struggling with these problems and negotiating the compromises that make a life in common possible" (pp. 16). As can be seen, inherent in the model is the assumption that all families have problems.

Minuchin (1974) proposes that the assessment is directed towards determining how the family is structured. The central assumption is that a problem (symptom) is the result of a dysfunctional family structure. A reorganization and the development of a functional structure should result in the elimination of the problem (Hoffman, 1981). According to Minuchin, "...structural family therapy must start with model of normality against which to measure deviance" (1974, pp.15). Of key importance for any therapist using this model is an understanding the conceptualization of normal family functioning.

The family is conceptualized as a social system embedded within a social context. According to Walsh (1982) the family system is considered to have three components. First, the

structure of the family is considered an "...open sociocultural system in transformation" (pp.12). Second, the family will and does develop through time and will be required to restructure itself with each stage of development. Thirdly, the family will continually adapt to it's changing situation in order to promote the growth of the individual members and maintain it's own existence through continuity.

The structural model proposes the use of certain constructs as a means of describing the organization of the family. Family structure, subsystems, boundaries, and hierarchies can all be determined in order to create a "map" of the family (Fish & Piercy, 1987). "Family structure is the invisible set of functional demands that organizes the ways in which family members interact" (Minuchin, 1974, pp. 51). The family system is seen to operate through transactional patterns. Over time the repetition of these transactions results in the development of enduring patterns. These patterns define the relationships between family members, including how, when and to whom each relates, and regulate behaviours accordingly.

The patterns that regulate behaviours are constrained by two systems (Minuchin, 1974). The first are the universal rules that control family organization. One example would be the power hierarchy between adults and children. In this

situation authority is structured on the basis of position and age within the family. Complimentary and reciprocal roles also govern these relationships. The second constraining system is "idiosyncratic", and is based on the mutual expectations that develop in families. These expectations develop over years through implicit and explicit negotiation. It is maintained by continued mutual accommodation, functional effectiveness, and habit (Minuchin, 1974). Not surprisingly they often become so intrinsic to the family that their origin has been forgotten. Families assume they are essential rather than optional (Nichols, 1984).

The family structure maintains itself through these preferred patterns, which are self perpetuating and resistant to change beyond a certain range. Minuchin (1974) notes that alternative patterns are available, but that deviations in behaviours that cross the system's tolerance threshold activate system correcting responses. The alternative patterns will only come into operation when changing circumstances create a stress that cannot be reduced through the present family structure. A functional family must then be able to adapt to internal (developmental) and external (environmental) changes.

Families can be differentiated into subsystems which carry out various family functions (Minuchin, 1974).

Subsystems can be formed by generation, sex, interests or function. A typical family will have numerous subsystems including a parental or executive, a marital, and sibling. Individual members will belong to a number of subsystems. In each, he or she will have different levels of power.

Individuals, subsystems, and the family system are separated by boundaries. Boundaries are the rules that govern and define who participates and how within each subsystem. Boundaries function to protect the differentiation of the system and the subsystems within it. "For proper family functioning, boundaries must be defined well enough for subsystem members to carry out their functions without undue interference, and at the same time must still permit contact with other subsystems" (Walsh, 1982, pp.12). Minuchin highlights that the composition of subsystems is far less important than the clarity of the boundary.

Boundary clarity is a major parameter used by structural therapist to evaluate family functioning. Minuchin (1974) sees boundaries varying along a continuum. At one extreme they can be disengaged, that is the boundary is inappropriately rigid. Disengaged subsystems can be considered relatively isolated and autonomous, as the rigid nature of the boundary blocks communication and impedes the protective functions of the family (Walsh, 1982). On the

positive side this promotes mastery, independence and growth, but it is at the expense of warmth, affection and support (Nichols, 1984). At the other end of the continuum are enmeshed boundaries which are overly diffuse. Enmeshed boundaries result in blurred differentiation between family members, and a heightened sense of belonging. Enmeshed boundaries affect members at the expense of mastery, independence and growth. Between these two extremes lie what are termed clear boundaries. Most families fall into this wide "normal range"

Enmeshment and disengagement do not refer to qualitative difference between functional and dysfunctional rather they refer to a transactional style, or preference to a type of interaction. In some respects the wide normal range takes into account the variation in boundaries that occurs due to cultural norms (Walsh, 1982). In addition, at different stages of family life what is optimal varies. For example, during the adolescent stage families must develop more disengaged boundaries around both the family as whole, and the adolescent subsystem. During the early years of a child this might be inappropriate. Families operating at the extremes of the boundary continuum do indicate and display possible pathology. Overly rigid or enmeshed boundaries that are maintained over time can limit the development of individual family members.

According to Minuchin (1974) boundaries also establish the hierarchical structure within the family. Of specific importance is the boundary around the parental subsystem. A clear boundary is essential if the parents are to hold leadership positions. In many respects Minuchin views the family's ability to function being derived from appropriate delegation of power and authority from the parental system down. An appropriate hierarchy will also mean a clear generational line.

Minuchin (1974) also conceptualizes certain structural triadic patterns that are seen to maintain dysfunction, or initiate the development of symptoms. Key concepts include; triangulation, coalitions, and detours. Triangulation involves a process where each parent demands that the child side with him or her against the other spouse. The child often becomes paralysed as siding with one is seen by the other as an attack. A coalition develops when two members, typically covertly, ally against a third. When the coalition rigidly crosses a generational boundary it can be considered a stable coalition. An example of a stable coalition would include a coalition between a parent and their child. Finally, detouring occurs when stresses between two parents gets redirected onto a child. Detouring allows parents to put aside their conflicts with each other and present a harmonious front.

Summary and Comments

The structural model provides a means for assessing family functioning, and for determining the nature of the organizational problem that produced the symptom. A succinct summary of a well functioning family is structural terms is offered by Hoffman (1981),

> "...an appropriately organized family will have clearly marked boundaries. The marital system will have closed boundaries to protect the privacy of the spouses. The parental subsystem will have clear boundaries between it and the children, but not so impenetrable as to limit the access necessary for good parenting. The sibling subsystem will have its own boundaries and will be organized hierarchically, so that children are given tasks and privileges consonant with sex and age as determined by the family's culture. Finally, the boundary around the nuclear family will also be respected, although this is dependent on cultural, social and economic factors. The extent to which kin or agents of larger social institutions are allowed in varies greatly" (pp.262-63).

Structural family therapy is also replete with numerous techniques. Minuchin and Fishman (1981) systematically describe define and provide examples of the interventive strategies a structural therapist can use in order to affect

change within the family structure and organization. One of the tenets of the model is that change is to be initiated in the therapy room. The idea is that the family can then take home with them the new found skills and behaviours they have learned.

The advantage of this model for families with adolescents is that it stresses the idea of families as social systems in transformation. "With this orientation, many more families who enter therapy would be seen and treated as average families in transitional situations, suffering the pains of accommodation to new circumstances" (Minuchin, 1974, pp.60). Thus particularly for families at a developmental impasse structural therapy holds strong promise.

Hoffman (1981) points out that, "It is a genuine limitation that although Minuchin's theory is most eloquent about family systems and family structure, it does not contain a comprehensive enough theory of change to cover the area misnamed "resistance", and the moves which deal most successfully with it, especially in cases of what Minuchin would call enmeshed families" (pp.270). Piercy and Sprenkle (1986) also note that structural therapy does not explore behaviourial patterns and interactions which occur out of session. Thus unless the behaviour is seen or discussed during the interview, it might not be addressed.

Walters, Carter, Papp, and Silverstein (1988) also identify some cautions in relation to the concepts of hierarchy and boundaries. Hierarchies are seen to disadvantage women and children when applied rigidly or in a sexist manner. They note that "...the concept of hierarchy often does not leave room for the female style of decision making in a more consensual or collective way, or for exerting authority (with children, for example) more through relationship than through explicit use of power" (pp. 24). According to Walters, Carter, Papp, and Silverstein (1988) the definition of appropriate boundaries is based upon the male model of closeness and distance in relationships. They feel this concept typically ignores female styles of interaction and understandings of relatedness. The concepts of hierarchy and subsystems have also been noted to be based on the two parent family model (Goodrich, Rampage, Ellman & Halstead, 1988). This puts single parent families at a disadvantage when an assessments is made strictly along the structural lines.

In general, structural family therapy does offer the clinician concrete tools in order to map the family's organization, and determine it's structure. The focus on subsystems, hierarchy and boundaries is particularly useful in assessing parent - adolescent problems, given that the major task is the redefinition of boundaries. It is important

however to remember that "from a structural perspective, no family style is inherently normal or abnormal, functional or dysfunctional. A particular family's differentiation is idiosyncratic, depending on its own composition, developmental stage, and subculture; any model is workable" (Walsh, 1982, pp.14). Given this understanding a therapist can choose to assist a family by identifying and correcting the dysfunctional structure which is inhibiting growth and maintaining the problem.

Solution Focused Brief Therapy

One of the difficulties for any family therapist is redefining the problem away from the adolescent, and expanding it to include the family system. The majority of families have already attempted to solve their problem, and failed. Often there are feelings of hopelessness and despair. Because adolescence can challenge parental competence at the best of times, seeking therapy can also add to the feelings of incompetence. Solution focused brief therapy offers both the family and the therapist an efficient and practical means for solving problems. Because the focus is on solutions and what is working, the model promotes cooperation and hope. This section will examine the solution focused brief therapy model developed by de Shazer and his colleagues at the Milwaukee Brief Family Treatment Center.

One of the rationales for a brief therapy approach is that most individuals, couples, and families only remain in treatment for 6 - 10 sessions (Budman & Gurman, 1988, de Shazer et. al., 1986, Fisher, 1984, Wells & Phelps, 1990). In addition, therapists have an ethical responsibility to provide the most efficient cost effective service (Sluzki, 1983, Trute, 1985). Fisher (1984) found that at the one year follow up mark, self reports on outcome showed no difference between treatment groups who received time limited, and unlimited treatment. He notes that time limits did not decrease the effectiveness or the durability of the outcome. Given these findings, a brief approach can be an effective means for promoting change within a limited time.

Defining brief therapy on the basis of time constraints is, however, misleading. Definitions range from number of sessions, to length of time in therapy (Budman & Gurman, 1988, de Shazer, 1985, Wells, & Phelps, 1990). An alternative definition proposed by de Shazer et. al. (1987), is "...a way of solving human problems" (pp.207). Solution focused brief therapy falls under the second definition.

Conceptually, whenever one seeks to understand a particular model, the first question to be asked is under what school of thought does it come under. Solution focused brief therapy falls under the category of strategic psychotherapy

(Rosenbaum, 1990). Specifically it is closely associated with the generic term strategic family therapy and the brief therapy model developed at the Mental Research Institute (MRI) (Fish & Piercy, 1987, Piercy & Sprenkle, 1986).

Strategic family therapy is heavily influenced by the work of Milton Erickson (Fish & Piercy, 1987, Piercy & Sprenkle, 1986, Rosenbaum, 1990). Rosenbaum (1990) provides a broad definition that refers to any therapy in which the therapist takes the responsibility for influencing people, and actively plans a strategy to promote change as strategic. Fish & Piercy (1987) have developed a profile of strategic therapy based on a consensus of opinion from 18 strategic therapists. According to their study a profile of the strategic model,

> " ...is based on the theoretical assumption that behaviour, which occurs as a part of a sequence of ongoing interaction recursive events can only be understood in context. Symptoms, ...are embedded in these sequences of interaction, and are developed and maintained by ineffective solutions. The strategic panel of experts do not perceive symptomatic behaviour as "inherently" problematic, but rather as construed as such, based on the reality that is created by the family.

Therapy, ...aims to change this reality, with a belief in the necessity of second-order change" (pp. 123).

In general the following can be considered distinguishing characteristics of the strategic model (Rosenbaum, 1990);

1. The role of the therapist is to influence people.
2. The client is met at his or her own world view.
3. A systemic epistemology is utilized.
4. The focus is on problems and their solutions.
5. Presenting problems are maintained by the attempted solutions.
6. A small change is all that is necessary.
7. Therapy is brief.
8. The therapist uses whatever the client(s) brings in order to assist them to develop a more satisfying life.
9. The concept of resistance is not used to explain or punctuate a clients behaviour.
10. A therapist in general must design a specific approach to each problem.

The above characteristics of strategic therapy can be identified in the perspective of de Shazer and his colleagues (Berg, 1990, Berg & Gallagher, 1991, de Shazer, 1984, 1984a, b, c, 1985, 1988, 1988a, b, c, de Shazer & Berg, 1988, de Shazer, et.al., 1986, de Shazer & Lipchik, 1984, de Shazer & Molnar, 1984, 1984a, Lipchik & de Shazer, 1986, Molnar & de

Shazer, 1987, Rosenbaum, 1990, Weiner-Davis et.al., 1987). Solution focused brief therapy however differs from the above characteristics in that the approach concentrates on solutions and how they work (de Shazer, 1988), instead of problems and how they are maintained.

In the past, brief therapy has also been termed problem solving therapy (Molnar & de Shazer, 1987, de Shazer, 1988b, Haley, 1987). Simply put, the goal is to identify the problem or symptom. Problems are assumed to be maintained by repeating interactional patterns. Once identified a solution can be developed to interrupt the pattern and meet the goal of therapy, the reduction or extinction of the problem (Haley, 1987). However, de Shazer (1988b) notes that, "Solutions have been examined only in relationship to the complaint, on the assumption that knowing the details and, therefore, understanding the complaint or problem is necessary for resolution" (pp. 48).

Solution focused brief therapy does not accept the assumption that the problem and the underlying causes have to be known in order to find a solution. Rather, it assumes that whatever the cause, the continuation of the problem is related to the context it occurs in, and the expectation that the problem will continue (de Shazer, 1988). Consequently the

focus is situation-centred, rather than person or family centred.

> "Given the complexity of complaint construction, it would seem reasonable that solutions would need to match that complexity. However, it is our view that interventions and solutions only need to fit within the constraints of the complaint in much the same way that a skeleton key fits within the constraints of many different locks" (de Shazer et.al., 1986, pp.212).

de Shazer (1988) believes that problems and solutions are similar to figure/ground relationships in the sense that solutions are the ground to the figure of the problem. "Without the idea that problems can be solved, what are called problems in the psychotherapy world would become just facts of life or unfortunate occurrence which could not be avoided and/or changed" (de Shazer, 1988, pp.7). Solutions are seen to develop out of the view of the problem. Thus any view that leads to the development of a solution is deemed useful.

de Shazer & Berg (1988) suggest that problems and their causes "...are simply a set of constructions about reality. While a variety of constructions focusing on the "causes" of problems have proven useful, they do not represent the only way of understanding therapy and change" (pp.42). The approach, suggests that solutions can be developed by

"...amplifying non-problematic patterns without attempting to determine what caused the problem" (de Shazer & Berg, 1988, pp.42). This is accomplished by the therapist systematically focusing the client on solutions and the future rather than problems and their causes in the past (Molnar & de Shazer, 1987). The theoretical position of the solution focused brief therapist can be seen as a shift from initiating change to constructing and initiating solutions (Lipchik & de Shazer, 1986).

The main principles and guidelines of the approach can be found in the initial conceptualization and subsequent development of a solution focus (de Shazer, 1985, 1988, de Shazer et. al., 1986). Problems or complaints requiring therapy are defined as involving a limited and restricted set of behaviours, perceptions, thoughts, expectations, and feelings (de Shazer 1988b, Molnar & de Shazer, 1987). These occur and are maintained through interactional patterns (de Shazer et. al., 1986). Solutions are seen to exist outside this restricted set. The client is often unable to perceive the patterns of interaction occurring in these areas. It is assumed that other sets of behaviour exist and generally involve a larger proportion of people's lives. "Therefore, the possible clinical interventions are much more numerous when the therapeutic focus in on non-problem behaviours" (Molnar & de Shazer, 1987, pp.257).

The role of brief therapy is to assist clients to discover the solutions outside the complaint. The solution focus, "...emphasizes exceptions to the rules of the problem rather that the rules of the problem itself" (Molnar & de Shazer, 1987, pp.350). Solutions are constructed around the assumption that nothing always happens, and nothing is always the same. However, most clients will describe complaints in terms of always (de Shazer, 1985, Berg & Gallagher, 1991). The formulation of a problem as a steady state is seen to promote feelings of hopelessness. Any exception to the complaint is a potential solution since it lies outside the constraint of the problem and the accompanying world view. de Shazer and Berg (1988) note that clients can often describe exceptions to the problem, but that these exceptions are not considered significant. "For the clients, these are not differences that make a difference; making these differences make a difference is the heart of the therapist's job" (pp. 42).

Solutions often involve simply doing something differently. This can mean changing behaviour, and/or the interpretation of the behaviour and situation (de Shazer et. al. 1986). In order to assist the client in discovering the "difference", the therapist needs to explore the constraints of the complaint. They suggest that a solution needs to "fit" within the constraints of the problem in order to allow for

the development of a solution (de Shazer, 1985, 1988, de Shazer et. al., 1986, Lipchik & de Shazer, 1986). Fit, "... deals with the relationship between the intervention and satisfactory positive patterns" (Molnar & de Shazer, 1987). The concept of fit also deals with the relationship between the therapist and the client(s), and involves the establishment of a rapport which involves feelings of closeness and responsiveness (de Shazer, 1988, Lipchik & de Shazer, 1986). When all participants are paying close attention to what the others are saying, fit can said to be established. Fit can be said to include, "...the therapist behaving in such a way that it is clear to his clients that he (the client) has everything needed to solve the problem" (de Shazer, 1988, pp.91).

Because the solution focused model follows a systemic epistemology, the system under consideration always includes the therapist (de Shazer, 1984, 1985, 1988). Distinguishing between the family as a system and the family - therapist as a system clarifies the focus on changing. The relationship between client and therapist is seen to be cooperative (de Shazer, 1984). In addition the therapist is responsible for the maintenance of the cooperative therapeutic relationship (de Shazer, 1985, Lipchik & de Shazer, 1986). The idea of resistance is seen as the clients' way of informing the therapist how to help them, and that the present intervention

doesn't fit (de Shazer, 1988, de Shazer et. al., 1986). As a way of encouraging cooperation the following approach is recommended;

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

Within the system under consideration the solution focus also assumes that only is small change is required. Thus only small and reasonable goals are necessary (de Shazer et. al., 1986). The belief is that "...a small change in one person's behaviour can lead to profound and far-reaching differences on the behaviour of all persons involved" (pp. 209). A corollary to this belief is that change in one part of the system will lead to changes in the system as a whole (de Shazer, 1985, 1988, 1988b). The model supports the concept of working with only one part of the system. de Shazer (1988) goes as far to suggest that it is more beneficial to only invite those persons who are most bothered by the problem to the sessions. As these persons are seen as being most desiring change.

Lastly, this model suggests that effective therapy can be accomplished even in situations where the problem is so vague that even the therapist cannot report what the client is complaining about (de Shazer, 1988). Because the focus is on solutions one only needs to know how the client will know the problem is solved (de Shazer et. al., 1986). Questions can be asked in order to clarify the goals. The more specific, concrete, and behaviourial the goals can be, the simpler the process of constructing a solution (de Shazer, 1988). de Shazer (1988b) notes that "The therapist's direct focus on solutions enables clients to talk indirectly about their complaints as they talk directly about solutions and potential solutions" (pp.54).

Solution focused therapy, like other forms of strategic therapy, attempts to solve the problem which is understood to be occurring outside of the interview room and therapy session. de Shazer (1988) views the interview as a process whereby a client's description of a problem is "shaped interactively" through the conversation between client and therapist. It is this description that is dealt with in therapy. Therefore, a primary task of the interview is to assist the clients change their method of constructing their experience. "This view assumes that a change in the way clients construct their experiences, as reflected in how they report it or talk about it, will promote their having a

different experiences which, in turn, will prompt different depictions or reports in subsequent sessions" (de Shazer, 1988, pp.77).

The initial interview sets the stage for treatment. From the outset the interview has certain purposes and goals. Specifically these consist of; developing rapport or fit, searching for exceptions, positive focusing towards solutions, and setting goals (de Shazer, 1988, Lipchik & de Shazer, 1986). Although they will be discussed separately, they do not consist of discrete and separate activities. Subsequent sessions evaluate the previous session, and continue to promote and develop a improved fit.

The initial stage of the interviewing process consists of building rapport in order to create a workable and task centred cooperative therapeutic system which includes both the client(s) and the therapist (Lipchik & de Shazer, 1986). Building rapport is an ongoing process during therapy, and the therapist is responsible for developing and maintaining rapport. The establishment of rapport is the process that leads to the "fit" between the client(s) and the therapist. It should be noted that the therapist is responsible for continuing to develop and promote "fit" throughout treatment.

Understanding and accepting the clients' worldview is essential for the development of useful solutions. The solution focused model suggests that it is useful to differentiate clients as "visitors, complainants, and customers". The labels describe the relationship between therapist and client, not the client (Berg, 1990, de Shazer, 1988).

Berg (1990) and de Shazer (1988) describe a visitor as someone who either does not believe there is a problem. The visitor can believe there is a problem but they do not think anyone can solve it. Frequently, this type of client has been coerced, mandated, or involuntarily referred to the therapist. Both authors note that ignoring these signs lead to setting up a resistive or uncooperative relationship. A complainant can be distinguished from a visitor by their identification of a problem. Often they can describe it in detail, and even have some ideas regarding how and what would be different if solved. However, they also do not see themselves actively participating in developing the solution. Often, the problem is someone else's responsibility, and the complainant is the victim. Finally, a customer relationship exists when a client explicitly identifies the problem, their goals, and is willing to do something about it. It should be kept in mind that when a therapist is meeting with a family, different members can have different relationships to therapy.

Berg (1990) and de Shazer (1988) point out that these descriptors are not clear cut, and do not follow an orderly sequence. Through acceptance of the clients position, the therapist is able to assist visitors and complainants to become customers. This process can be aided by the use of tasks, as the descriptors inform the therapist regarding task assignment (Berg, 1990, de Shazer,1988). They suggest that visitors simply be complimented. Any discussion of the problem should be from their point of view, and the therapist must be on the family's side. Since complainants agree there is a problem, and that something should be done about it, the authors suggest an observational or thinking task, keeping in mind he or she does not feel they own the problem. The task needs to agree with their perception of having an observer status. Customers are willing to accept behaviourial tasks. In each of these situations, task compliance validates initial assessment of the relationship, and encourages clients to return for another session (de Shazer, 1988).

The formulation of these relationships is particularly useful for families with adolescents. One can easily imagine an adolescent entering as a visitor, and their parents as complainants. Identifying the relationship assists the therapist to fit a response to each member, and to assign initial tasks accordingly. de Shazer (1988) notes that in some cases it creates confusion to continue to invite visitors

to later sessions. This suggestion follows the principle that a change in one part of the system will have a ripple effect.

During the initial interview, the therapist also begins to search for the exceptions to the rules or set of the problem. Searching for exceptions begins the shift away from the problem and towards a solution. Questions such as "are there any times the problem doesn't occur, is less frequent, is less intense?" can begin this process. The solution focused therapist is interested in how the client accounts for the exceptions, and attempts to determine "what is different about those times?" (Lipchik & de Shazer, 1986). Exceptions are the beginnings of solution construction. de Shazer and his colleagues note that this is a key characteristic of a solution focused interview, and that more often than not exceptions can be found (Berg, 1990, Berg & Gallagher, 1991, de Shazer, 1985, 1988, 1988a, b, c, de Shazer, et.al., 1986, Lipchik & de Shazer, 1986, Molnar & de Shazer, 1987, Weiner-Davis et.al., 1987). The goal of the interview is to answer the question "what happens when the complaint does not?" (de Shazer & Berg, 1988).

Lipchik and de Shazer (1986) suggest that when no exception can be discovered, the therapist simply continue to explore the rules to the problem and the complaint "reality". Areas recommended for exploration are the clients' ideas

regarding solutions, and what would they notice when changes begin to occur. Interventions in these situations will often include the client(s) examining more closely whether any exceptions are occurring that had previously not been noticed.

Searching for exceptions is complemented by a positive focus towards solutions which encourages clients to begin to project the situation into the future. By using this approach the therapist implicitly connotes change as inevitable (Lipchik & de Shazer,1986, Molnar & de Shazer, 1987). "Therefore, the therapist stance is not <u>if</u> change will occur, but rather <u>when</u>, or <u>where</u>, or <u>what type</u> of changing will occur" (de Shazer, 1984, pp.16). This stance of expecting and promoting change provides an optimistic focus. This can be maintained through the active use of questions and specific language. Words such as "might", "would", "if", and "could" can convey a tentative outlook, as opposed to using "when", "can", "will", or "shall" which all imply expectations of change. "The therapist's positive stance is different form the client's negative one and represents another opportunity to facilitate new perceptions and behaviours that can lead to solutions" (Lipchik & de Shazer, 1986, pp.94). This positive approach can also be considered to promote the amplification of non-problematic patterns of behaviour within the system (de Shazer, 1984).

Whether an interview has produced an exception to the problem or not, goals have to be set in order provide direction and a means for evaluating the outcome. de Shazer (1988) suggests that it is useful to think of a goal "...as some member of the class of ways that the therapist and client will know that the problem is solved rather than any particular member of the class" (pp.93). Ideally, "the goal is a small piece of the solution expressed in the most specific behaviourial terms possible in order to serve as a useful guidepost toward solution" (Lipchik & de Shazer, 1986, pp. 94). An example of a specific goal would be an adolescent coming home on time for a specified number of days in row.

Sometimes the complaint is more confused and vague, such as a parent stating they want their adolescent's attitude to change. In situations like these, the therapist must assist the parent(s) in determining how they would know that the desired change had occurred. What would be the signs it was happening, what would be different, what would they be doing that was different?, etc.. Lipchik and de Shazer (1986) report that "reducing the broader vague complaint to a more specific one makes the solution appear simpler and more attainable" (pp.95).

When no exception is discovered, and the development of concrete goals has been unsuccessful, the therapist must react

in a cooperative manner by maintaining rapport and promoting fit (Lipchik & de Shazer, 1986). Accordingly, the therapist must not become frustrated, rather he or she must accommodate to the client(s), perhaps even complimenting them on the extreme difficulty of the problem. de Shazer (1985, 1988) has found that an invariant task best fits these situations. The Brief Family Treatment Center (de Shazer, 1984b, 1985, 1988, de Shazer & Molnar 1984a), has experimented with this task, "Between now and the next time we meet, we [I] would like you to observe, so that you can describe to us [me] next time, what happens in your [pick one: family, life, marriage relationship] that you want to continue to have happen" (1985, pp.137). This task was designed to shift the focus from the past towards the present and future, while implicitly promoting change (de Shazer, 1985). The task has repeated resulted in distinctive accounts of exceptions upon which solutions were be built (Lipchik & de Shazer, 1986).

Whatever the outcome of the initial interview, the task prescribed must fit the complaint and the world view of the clients. The major goal of any intervention is to promote solution behavior. Often this means any behavior that is different (de Shazer, 1988). Most importantly the tasks and intervention must assist in the development of clients noticing the differences that make a difference

All subsequent sessions build on what was begun in the first interview. the therapist will generally check on task completion, and what was noticed. Even if there is no immediate response the therapist's persistence regarding any change often can uncover a small but positive change. If there has been absolutely no change the therapist continues to develop and promote fit.

Summary and Comments

In summary, "Solution-focused therapy seems, at this point, to represent a distinctive synthesis of Ericksonian indirection, an emphasis on functional systemic behaviour, and a future orientation in therapeutic practice" (Molnar & de Shazer, 1987, pp.351). Generally it can be defined as a form of strategic therapy. However, "the techniques for constructing solutions to particular complaints are not necessarily connected to the nature of the complaints themselves" (de Shazer, 1988b, pp.55). Therefore the focus on the exceptions which exist in any problem pattern, and the emphasis on solutions guide the therapist to specific methods of interviewing and intervention.

The solution focused approach offers the therapist an alternative to focusing on problematic interactions. The approach assumes that people in general do desire change. The

positive focus away from a problem saturated world view encourages client to identify effective solutions to their problems. It is a model that encourages and promotes health, ability, and competence.

The solution focused approach is an orientation a therapist follows to promote change. There are specific guidelines to follow. The therapist is responsible for the relationship. He or she must promote "fit", understand the clients' worldview, search for exceptions, and project the client(s) into the future. Yet the approach focuses on what fits for the client, not what fits for the approach. By focusing on what client brings with them, and employing their own resources for change the model supports and promotes strengths (de Shazer, 1988). The Milwaukee Brief Family Treatment Center has reported impressive postive outcomes based on self reports and six month follow up telephone surveys (de Shazer, 1988). There has been little external validation of these reports.

Conclusions: An Integrated Approach

Sluzki (1983) points out that in any sample of the family therapy literature each model "...tends to be presented by their proponents as the, and not a, translation of the systemic paradigm, as the privileged set of observables and hypotheses" (pp.469). This is certainly true with both the

structural and strategic models which have often been compared and contrasted. Fish and Piercy's (1987) study of the two concluded,

> "...that both approaches: (a) are present focused, (b) are change, rather than insight, oriented, (c) view problems in their relationship context, (d) give directives, (e) assign tasks, (f) are interactional, or contextually oriented, and (g) are goal directed and concerned with the outcome of therapy. While many similarities exist between the two approaches, the final profiles of structural and strategic family therapies yield two distinct schools of thought" (pp.123).

It is clear that there is not an integrated model that can presently claim conceptual clarity. Structural and Strategic (in this case solution focused) approaches are similar yet distinct. Fish and Piercy (1987) believe that learning an integrated approach must at a minimum be preceded by an understanding of the theoretical distinctions between the two. This can also be accomplished through supervision focusing on only one approach. Or by ongoing supervision emphasizing the distinctions between the two.

There may be advantages when more than one approach is used. de Shazer (1984b, 1985) discusses what he terms the poly-ocular view which occurs when more than one approach is employed. He believes the synthesis of these viewpoints

produces a "bonus" in that a new view results of a higher logical type. He further suggests that each approach to therapy can offers a valid interpretation of the same situation. Structural and strategic models can be compared with two eyes looking at the same clinical situation (de Shazer, 1984b). Depth is developed through the use of multiple viewpoints. "Multiple descriptions, while sometimes confusing, can enrich our vision and give us a better understanding of the whole process of therapeutic intervention and problem solution" (de Shazer, 1984b, pp. 36).

Each of the models examined has its adherents. However, as any clinician is aware, what works with one family does not always prove effective with another. Families with adolescents can be one of the most challenging type of family to enter therapy. The proposition that problems are a result of blocked or stalled development suggests that the presence of a problem is not solely the result of pathology or family dysfunction. The majority of families have areas of competence in which they are functioning effectively. It is therefor essential to capitalize on these strengths and assist in the transition to a new stage, in the most efficient and effective manner possible. When the problem is not a result of a transitional impasse, a focus on strengths and abilities promotes hope, and cooperation with the therapeutic process.

The higher logical type which develops goes beyond enriching the therapists understanding of the therapeutic intervention and problem solution. Each model also has an influence on the understanding and utilization of the other. The expanded viewpoint offered by the utilization of the structural and solution focused approaches offers a reasonable and effective treatment modality for families with adolescents experiencing problems. It seems clear that if one can maintain a conceptual distinction, the use of two models offers a greater potential for change to both the therapist and the family.

Chapter 3 - Organizational Aspects of the Practicum

Setting

This practicum was completed at the MacNeill clinic in Saskatoon, Saskatchewan. The clinic provides child focused mental health services for the Saskatoon mental health region, and is funded by the Department of Health. Services include individual, group and family therapy, and consultation to other service providers. Referrals to the Clinic are made directly by the family or by other social services (eg. mental health, child welfare, economic assistance, schools, hospitals, doctors). The staff is multidisciplinary, consisting of social workers, psychologists, and psychiatrists.

The clinic is divided into three teams, Early Childhood, Mid Childhood, and Youth and Family. This writer was attached to the youth and family team. Families referred to this team are those with presenting problems that include a child 12 to 18 years old as the presenting problem. This practicum was completed while functioning as a family therapy intern on the youth and family team. This team utilizes a systemic therapy approach incorporating elements of both the structural and solution focused models. The structural model is primarily

used for assessments, and tracking of family change. The solution focus organizes the interviews and the intervention used.

The internship program also includes a weekly seminar. Initially the seminar was organized as a therapeutic team. An intern or staff member would interview a family in front of the one way mirror. A consultation break would occur and a message from the team behind the mirror would be delivered by the therapist. This writer had the opportunity to both interview, and be a member of the team.

Part way through a new format was initiated using the reflecting team model (Andersen, 1987, Davidson, Lax, Lussardi, Miller, & Ratheau, 1988). This approach utilized a break about three quarters of the way through the session, and involves the therapist-family system and the team system exchanging places. The family and the therapist then observe the team discuss the interview and speculate on possible meanings and observations. This writer had the opportunity to both interview one of his own families and function as a member of the reflecting team.

Clients

The client group for this practicum consisted of families with adolescents who had been referred by community sources (e.g. social services, schools, doctors, clergy) or by the families themselves for therapy in order to resolve outstanding problems. Identified problems included; parent - adolescent conflict, physical and sexual abuse, suicidal ideation, and adolescent behavior problems involving delinquency, truancy, aggression, running away, social withdrawal, physical violence, and deteriorating or poor school performance.

In order to provide for a broad range of clinical experiences, this practicum did not set any limitations based on family form. Treatment was provided to intact, single parent, blended, and foster families. In all cases, a systemic orientation combining a structural model and a solution focused approach was utilized. All families were selected and assigned by the clinical director of the Youth and Family Team. Table 1 provides a description of the families who participated in therapy during this practicum.

Table 1

Summary of Family Type, Presenting Problems and Number of Sessions

Family	Type	Presenting problem	# Sessions
A	single parent	daughter not living at home, suicidal ideation	2
B	intact	daughter running away and defiant behavior	4
C	intact	poor attitude and academic performance	4
D	foster	unresolved grief, low self esteem, poor peer relations and academic performance	3
E	foster	physical abuse, death of parent, parental rejection	11

Table 1 (con't)

Summary of Family Type, Presenting Problems and Number of Sessions

Family	Type	Presenting problem	# Sessions
F[1]	adoptive	excessive tantrums	2
G	single parent	excessive fears, low self esteem	4
H[2]	intact	sexual abuse	7
I	intact	emotional outbursts	6
J	single parent	parent adolescent conflict	7
K	single parent	parent adolescent conflict poor academic performance	3
L	single parent	parent adolescent conflict	7
M	intact	suicide ideation, truant	4
N	blended	expression of anger	4
O	single parent	excessive conflict	4

[1] Identified problem was 7 year old adopted boy with FAS

[2] Client was 16 yr old daughter, abuse by older sister was disclosed to parents at end of contract with this writer.

Personnel

This writer was the primary therapist in all cases included in this practicum. Clinical supervision was provided by Mr. George Enns MSW, the director of both the Family Therapy Internship Program and the Youth and Family Team, and Mr.Paul Doerksen MSW, a staff member of the youth and family team. Supervision with each was held weekly and included; discussion, case planning, videotape reviews, and live supervision. This writer also attended the weekly team meetings, and the Wednesday morning seminar. External supervision of the practicum was provided by Dr. H. Frankel.

Procedure

A model of systemic family therapy which combined a structural assessment with a solution focused interviewing and interventive strategy was utilized. Interviews occurred at the MacNeill clinic, and were videotaped or observed whenever possible. Interviews were approximately one to one and a half hours in duration. During the initial assessment phase, appointments were scheduled on a weekly basis. Once assessment and contracting were completed, interviews were typically arranged for once every two weeks. The two week interval provided a reasonable time for tasks to be accomplished while reinforcing a view of family strength.

The MacNeill Clinic endorses a specific interviewing model which was utilized during this practicum. Initial interviews were to be expected to follow the following areas;

1. What is the problem ? - this should include a clear statement of the problem from each family member.

2. What is the family's understanding about why this problem exists ? - questions in this area are meant to explore the family's logic and world view of the problem.

3. How has the family been influenced by or dealt with the problem ? - the therapist is directed to develop a process description of the behaviour patterns in the family, and around the problem. Answers indicate and expose the family's structure, attempted solutions, stuckness, and problem solving approach.

4. What occurs when the problem doesn't, or what are people doing differently when the problem is not present ? - clear, concrete, and behaviourial descriptions are required.

5. If a miracle occurred and the problem was suddenly resolved, how would things be different ? - clear and concrete descriptions are required of how people would behave differently.

This model encompasses elements of both structural and solution focused therapy. In addition it allows for an understanding of the problem prior to the initial development of a solution. The last two questions are meant to allow people to step away from the problem and begin to analyze their own and each other's behaviour. They also help the therapist determine what tasks should be assigned. In addition to the above question the therapist is expected to develop compliments for each family member. Compliments are to be composed from information offered during the session and ideally will utilize the family's language in order to encourage "fit".

All families were requested to complete and participate in the evaluative mechanisms of the practicum. This included the completion of both a pre and post-test measure (FAM III) (appendix A), and an ongoing time series measure based on the Morrisson checklist (appendix B). A debriefing session was held at the termination of treatment in order to provide a format for families to discuss their experience in therapy and provide direct consumer feedback (Appendix C).

Duration

The practicum was of a four month duration, from January 7, to April 30, 1991. The internship program involved full time study and practice five days a week over the full four month period.

Recording

Recording followed the procedures and format set out by the MacNeill Clinic. An initial assessment was completed within two weeks of the first interview. The initial assessment included relevant background information, identified problems, assessment of family functioning, and proposed treatment plan. Interns were expected to document all subsequent interviews . This format required reports on the focus of each session and the interventions utilized. Client progress was evaluated each session and was based on both this writer's and the clients' perceptions. A personal log was kept of detailing learning experiences from the internship.

Chapter 4 - Evaluation

Criteria for Evaluation

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

The evaluation of family systems practice includes all the previous constraints but poses the additional difficulty of an evaluating a more complex process. Trute (1985) states

that "the scope of assessment must reach beyond the study of the behavior of one person to the behaviourial patterns of several individuals in an interacting system" (pp. 102). He believes that the system under consideration must include multiple levels of communication at both the verbal and non-verbal level. Thus, it is essential to use multiple measures in order to evaluate the family system's therapeutic process (Trute, 1985).

According to Bloom and Fischer (1982) multiple measures allow the practitioner to increase reliability, validity, and utility.

> "The use of more than one measure of the same problem deals with multidimensional changes and the fact that different measures may have low correlations. More specifically, using more than one measure helps to balance reactive and nonreactive measures, general and specific measures, internal and external measures, subjective and objective measures, and direct and indirect measures" (pp. 225).

Bloom and Fischer (1982) suggest the following guidelines are useful for developing a effective measurement package. The practitioner should first select a primary measure that is the closest to or the most direct expression of the problem. It should also be the one in which one would most expect

change to appear, and has the highest priority for change. Additional measures that are less directly related to the problem should then be chosen. Secondary measures should supplement or complement the primary measure. They can be less direct, more general, and subjective. The combination should provide for access to more than one dimension of the problem. Supplementary or tertiary measures should be from the perspective of others people concerned with the problem. Using multiple measures allows for a multiple perspective on the problem, and can include the point of view of the client, the practitioner, and others not directly involved in the intervention process. If one has two of the above three perspectives on the problem one has the ability to access a wide scope of data while taking into account issues of reactivity, in addition to balancing the strengths and weaknesses of individual measures.

Multiple measures were used in the evaluation of this practicum. The measurement package utilized provided a means to evaluate both the outcome of treatment and skill development as a family therapy intern. The primary measure, FAM III evaluated the outcome, through the use of a pre and post test. This measure addressed change from the practitioner's point of view. The secondary measure was a

problem checklist. Although it is problem specific, it is considered less reliable. It was used to complement the primary measure.

Evaluation Procedure

The outcome of the treatment process was evaluated through the use of a single system design that was used for each family. The measurement package included a pre-test, post-test design using of the Family Assessment Measure III (FAM III) as the primary measure. A problem checklist adapted from the Morrisson Problem Checklist was used as a secondary measure on a time series basis.

The evaluation of the writer's level of skill development was made from two different perspectives. The first perspective was through formal supervision which included consultation, review of videotaped sessions, and live supervision with each clinical supervisor. The Family Therapy Intern program at the MacNeill Clinic includes a midterm and final evaluation. This was considered part of the practicum evaluation package.

A second level of evaluation was derived from client feedback. This was achieved through a debriefing session with eleven of the fifteen families seen during the practicum.

Each family was asked to describe and discuss their experience in therapy, and to share their perception on what was found to be effective and helpful, and what was not. A consumer evaluation used at Family Services of Winnipeg Inc. was used to facilitate this process.

Evaluation Instruments

1. Family assessment measure III (FAM III)

FAM III (Skinner, Steinhauer, & Santa-Barbara, 1983) is a self report instrument that assesses family functioning in terms of both weaknesses and strengths. The measure is based on Canadian norms for both clinical and non-clinical populations (Trute, 1985). It is also based on a process model of family functioning that integrates varying approaches to family therapy (Skinner, Steinhauer, & Santa-Barbara, 1983). "A unique aspect of this of this measure is that it offers information in regard to overall family functioning and examines significant dyadic relationships in the family, as well as taps each individuals' perception of his or her functioning in the family" (Trute, Campbell, & Hussey, 1988, pp.17).

The General Scale is comprised of 50 items, and assesses overall family functioning. Information is provided on six factors of family functioning; task accomplishment, role

performance, communications, affective expression, involvement, control, and values and norms. It also includes response style bias, and measures of social desirability and defensiveness. FAM III has excellent psychometric properties (Trute, et.al., 1988). FAM III has an overall alpha score of 0.93 demonstrating strong internal consistency and reliability between scales. FAM III was also shown to discriminate between clinical and non-clinical families (Skinner, et.al., 1983).

2. Problem checklist

The problem checklist provides a self report from the clients regarding levels of satisfaction of each family member. They are generally considered weak in terms of generalizablity and empirical strength (Trute, 1985). However they do provide a method for evaluating the attainment of treatment goals.

This practicum employed a problem checklist (Appendix B) which was adapted by this writer from one developed by the Morrisson Centre for Youth and Family Services. The original checklist is not copyrighted and is considered to be in the public domain. Its use over a time series will be used to evaluate the attainment of goals related to the presenting problem. The checklist rates satisfaction with different

areas of the family life. It is expected that problem areas will be rated dissatisfactory. A positive outcome will include problem areas being rated at a more satisfactory level. A problem checklist such as this is considered to have low reliability and validity (Bloom & Fischer, 1982).

3. Formal supervision

Supervision occurred on a weekly basis with both George Enns MSW, the director of the Internship Program, and Paul Doerksen MSW, a staff member. Interns also participated in the weekly family therapy seminars discussed previously. Interns were expected to interview families, and to be a member of the team behind the mirror. de Shazer (1988), notes that there is a bonus present when two or more perspectives are considered on any given situation. It is believed that the supervision arrangements produced this kind of synergistic bonus.

The internship program provided formal midterm and final evaluations. The purpose of each evaluation was to review progress and learning and to identify future learning goals and directions.

4. Client feedback

All families who received service during this practicum were requested to participate in a review session at the termination of therapy to discuss their experiences with this writer as the therapist. A consumer feedback evaluation form (Appendix C) was employed to facilitate discussion.

Chapter 5 - Case Examples and Results of Evaluation

Introduction

This section of the report will examine the results of the practicum. First, a general overview of the results will be presented. This will include a summary of the results obtained and conclusion regarding the utility of the evaluation instruments. Three case examples will be provided in order to illustrate the therapeutic model utilized in this practicum. The case studies will attempt to illustrate how the interventive strategy was utilized through descriptions of the therapy process. Case examples will include clinical observations in addition to the results of the FAM III General Scale, and the problem checklist. An attempt will be made to demonstrate how the evaluation instruments complemented and supported both this writer's and the family's perception of the changes which occurred.

Summary of Results

Treatment was provided to a total of fifteen families during the course of the practicum. Of the fifteen, one (family B), declined to complete any of the evaluation instruments. One other (Family H), did not complete the post test component of the evaluation package. As a result this practicum generated data for a total of thirteen families. Of

the fifteen only two families dropped out of therapy during the course of the practicum (Family A & B).

Overall, neither of the instruments caused any undue difficulty for the families who participated in therapy. Nor did the use of the instruments interrupt or interfere with the treatment process. The families expressed some curiosity about the nature of the instruments and supported the principle of evaluating the effectiveness of service supplementary to their own self reports.

The FAM III questionnaire was found to be the most useful measure from a clinical perspective. The pre test scores generally provided a confirmation of clinical impressions, and the degree of difficulty the family was experiencing. The post test scores provided results reasonably consistent with the perceived treatment outcome. Appendix D provides the results from each family member that attended the sessions and completed the pre and post test FAM III measure.

In general, the parent who initiated the request had the highest overall score. This supports the idea that whomever is most concerned about the problem requests therapy. When the family was referred through a third party such as child welfare, or a school it was noted that the person identified as the problem had the highest overall rating. For the most

part the FAM III profiles presented a view of the family which was congruent with clinical observations. Where each member differed in their scoring, generally fit with the perceptions and viewpoints identified during the initial interview.

One trend was the change in the denial and social desirability scores at termination. In two cases the increase was sufficient (greater than 50) to call into question the validity of the other scales (Skinner et. al., 1984). This trend was particulary apparent with the families who felt that therapy was successful. It is speculated that the development of a relationship with the therapist was related to this increase. During the termination sessions it was noted that the majority of the families made specific efforts to show their appreciation. It is believed that the increase in the social desirability scale was one of the means by which families attempted to show their gratitude, by satisfying what they perceived would be pleasing to the therapist.

The problem checklist (Appendix B) was not found to be as useful as the FAM III rating. Although it did provide a problem specific measure, many of the areas identified incorporated only one facet of the perceived problem from each individual's perspective. Its major utility came from the multiple perspectives it provided regarding the perceived problem. One unanticipated result were the changes in the

ratings overall when treatment was successful. These changes support the view that a problem influences how one perceives all areas of life, and that the elimination of a problem has a ripple effect into other areas. de Shazer (1988) notes that utilization of the solution focus allows for indirect therapy in the sense the problems not identified also improve. This certainly could be interpreted through the results of the problem checklist.

In general, it is felt that the problem checklist did not "fit" appropriately with the model of therapy utilized. Because the solution focus is on strengths and abilities, a checklist on problems might have been counter productive at the termination point. During the practicum a scaling question rating goal attainment was utilized. In hindsight this would have been a more appropriate and problem specific secondary evaluation instrument. A self anchored rating scale has two advantages: it can be used each session, and it can be considered more problem specific as it is tailored to match each specific family. In addition the rating scale utilized was directed towards the future, and was solution oriented. Overall, it would have made a more appropriate evaluation instrument both in terms of utility and orientation.

The consumer evaluation (appendix C) utilized at termination also provided useful feedback regarding the therapy process. Families were generally satisfied with the service provided. They stated that they felt they had been understood, that the therapist was genuinely interested in the problem, and that the service provided met their expectations. No family reported any statements or actions to have been unhelpful. One family noted that initially they had felt that there had been a communication problem with the therapist. However, they felt that this had been addressed during treatment but saw it as contributing to the initial difficulty solving the problem. By far the most interesting results were obtained from the question regarding what families found most helpful. In almost all cases a specific idea, instruction, or statement was identified and described as contributing to the changes which occurred. Typically each member identified a different point. There were, however, some similarities which were identified across a number of families, these included; compliments, identification and clarification of the different viewpoints of family members, paraphrasing of statements, statements which suggested the problem was almost solved, and identification of improvements which hadn't been noticed. Although some of these can be related to sound interviewing practice, the majority are specifically related to techniques specific to a solution focus.

On a number of occasion, ideas found to be helpful by the family were ideas that had not been previously identified as clinically significant by the therapist. A significant amount of new learning was derived from the consumer evaluations at the end of therapy.

Case Examples - Introduction

The selection of the following case examples was made on the basis of a number of factors. First, there was a desire to present a variety of family forms in order to demonstrate the applicability of the model. Secondly, an attempt was made to strike a balance between the degree of difficulty on intake and the outcome as a means of supporting the utility of the approach. The final choice was made on the basis of which cases provided the clearest illustration of the therapeutic model used during the practicum.

In each case an initial assessment was made in the first session. This included an assessment of family functioning. Interventive strategies followed a solution oriented approach which included maintaining rapport, the use of the miracle question, compliments, acceptance and comprehension of each individual's worldview, searching for exceptions, and the amplification of strengths and abilities.

Case Example 1 - "If you don't ask, You won't know"

Ernie (15) and his parents were referred by the high school guidance counsellor. According to the counsellor Ernie had commented to his teachers that his problems at school would stop when he did. This was understood as a suicidal threat, and the parents were notified. When Ernie was questioned by his parents about these statements, he informed them that he only had wanted to get the teacher's attention.

The school had recommended that the family seek therapy. Both parents were concerned over the number of classes Ernie had skipped and felt that something was bothering him. As a result they contacted the Clinic to arrange for therapy.

Sid (46) and Ruth (45), the parents of this intact family of four, both worked full time. Sid was an aide in a care home, and Ruth worked at the town hotel. Both parents were concerned about the lack of employment opportunities and had tried to encourage their children to obtain a good education. The two eldest daughters (23) are twins and lived on their own. Left at home were Tom, (21) who is unemployed and Ernie (15).

According to the parents both daughters had typical teenage years. They were popular at school and did quite well

academically. When Tom was fifteen, they were referred to the Clinic for counselling concerning Tom's poor peer relations, school performance and self esteem. Tom was seen individually and the family thought therapy had been helpful. Tom completed high school with no further difficulty.

Concerns about Ernie developed in October of 1990. The parents noticed that he appeared bothered, but made no serious attempts to determine the cause. In November they were notified by the school that Ernie's attendance was slipping. They discovered that Ernie had been spending time with his friends during the day, while pretending to attend school by keeping the same hours. They were concerned that he was no longer interested in school, and was envious of his friends who had dropped out for the easy life. At the time the family entered therapy Ernie was functioning below his abilities at school. He stated that he was unsure whether he would continue his education. He identified his peers as the major problem at school. He felt he did not fit in, and was bothered by comments which were made about him, and his brother.

The parents agreed to having a team behind the mirror for the first session. In attendance were both parents, Ernie, and Tom. The family presented as a concerned but cautious unit. Both parents talked about their concerns in a manner

that seemed to minimize any strong expression of feeling. Ernie presented as a somewhat depressed and introverted adolescent. Tom appeared disinterested and somewhat put out by having to attend.

Initially the problem was described as poor school attendance, and a lack of motivation. The parents felt Ernie just was not interested, and this would effect his future employment opportunities. It quickly became clear that the family as a rule avoided all forms of conflict. Members spoke about being careful not to hurt each other's feelings. Tom had been unemployed for over a year, and Ernie had missed a significant amount of school. Neither had been openly challenged in a direct manner. The father appeared to care deeply for his children and his wife, but remained distant and emotionally disengaged. All family members made an effort not to bother him, or involve him in their issues. Although the mother was willing to confront family members she felt she was not taken seriously. She described how she stored up her feelings of frustrations and would regularly "explode". Sid and his sons all described how they would leave the home to let her calm down. They saw her as emotional and high strung.

About half way through the session, the parents were asked about the school's concerns regarding suicide. This subject had yet to be mentioned. Both parents felt that this

had been a misunderstanding, and stated they were not concerned. Ernie was then directly questioned as to the meaning of his statement to his teachers. He quite calmly disclosed that he had strongly contemplated suicide, and on a number of occasions had attempted to strangle himself. This was new information to the parents who had not questioned Ernie's statement that he had just sought attention. Both appeared quite shocked. Ruth was visibly upset. Ernie was complimented on his honesty and courage to disclose the burden he had been carrying by himself.

Both parents were asked how they understood this new information. Sid felt it was an example of how the family had not been open in their communication with each other. Ruth added that she thought Ernie was finding it hard to follow in his sisters' footsteps. Ernie, however, clearly saw himself being different from his peers and not fitting in. There was "lots of stuff" that he couldn't talk about with anybody, and he was especially fearful of telling his parents. He thought that they would become angry and not understand, and that he would have hurt their feelings. He tried to cope by keeping his feelings to himself. This was a pattern all family members seemed to utilize. Both Ernie and his family noted that talking to one another could frequently lead to conflict. Although the mother's behavior was an exception, she was usually not taken seriously.

Each of the family members was asked the "miracle question". If a miracle happened tonight while each of you was sleeping what would you notice the next morning that would be different? The father, Sid, noted that he would spend more time with his children and wife, and that there would be more open communication. Ruth agreed with her husband. She also noted that Ernie would be more talkative, and would regain his interest in school. She thought he might openly volunteer information about his day. She also thought that she would be less frustrated around the house and with her family. This would mean that she would "blow up" less often, and that the circumstances that led to these episodes would be resolved. Ernie thought he would be less concerned about what his peers thought, more interested in school, and that his parents would be less judgemental. Tom thought there would be less tension in the home, and that he and Ernie would talk more and fight less. He stated that he had discovered the benefits of expressing his thoughts and feelings even when others do not agree. He thought Ernie would also discover the benefits of this approach.

At this point a consultation break with the team was called. During the consultation it was agreed that on a practical level the family was functioning adequately. However it was felt that at an emotional level each of its members operated in isolation. This disengaged style of

interaction was seen to protect the family from intensity and avoid overt conflicts. At the same time it served as an obstacle to problem solving and affective expression. It was noted that the family's hierarchy was unclear, and both parents seemed uneasy about taking a stronger leadership role in the family. It was apparent that overly rigid boundaries had developed between subsystems and between members. This was understood as impeding the flow of information, especially at an affective level.

The remainder of the consultation break was spent developing compliments for the family which were delivered following the break. Ernie was complimented for his courage to be open and for challenging the family tradition that he had accepted until that day. He was told the team wondered what further information he would share, and who would be the first to have the freedom to let him know that they wanted to know more. Tom was told that we admired his persistence and determination, and how he had discovered the benefits of expressing himself and the freedom this allowed him. Both parents were complimented on their concern for and commitment to their children. The father was commended for recognizing the importance for the family to communicate more openly in order to solve the present problems. The mother was told that the team was impressed with her ability to recognize that each of her children was a unique individual. She was also told

that it would be important for her to be taken more seriously. She was told that the team noticed how much of an impact it had on her when Ernie began to discuss his pain and sorrow. Both parents were asked to consider what the impact on the family will be when they let their children, especially Ernie, know that they are open to more information about their lives.

After the messages were delivered, this writer spoke with Ernie regarding his suicidal ideation. He agreed to a no suicide contract, and a safety plan was arranged in case he felt suicidal. The family was offered a contract of up to five sessions. The problem was defined as a lack of open communication. Ernie's disclosure at the school and in the session were identified as exceptions. Ernie, and his family were able to confirm that both these events had helped him to feel better are were examples of more open communication. A second appointment was arranged for two weeks time.

Ernie and his parents attended therapy for a total of four sessions. Ernie's older brother, Tom, chose not to attend, and this was met with no resistance by the family. By the second session, each noted that the problem seemed to be improving. Ernie's affect appeared to have improved, and he was described as being happier and somewhat more talkative. In addition Ernie appeared to be enjoying school more, and was seen to have had an increased ability to concentrate.

During the session, however, it became clear that the family members had not shared their observations with each other during the previous two week interval. Each was surprised to discover that the others felt the same. In particular Ernie reported no further thoughts of suicide since the last session. Although the parents had believed this to be the case, neither had felt it was wise or possible to question him about it. The family agreed that although there was increased open communication between members, further improvements would be required in order to avoid similar problems in the future. Prior to entering therapy, direct questions had been avoided so as to not hurt the feelings of another. The family now understood that in doing so they may have caused more harm than good.

By the time the family attended the third session, the above difficulty had been resolved. At this point all family members felt that the problem was well in hand, and that they were doing quite well. Of note was Ernie's renewed interest in school, and his newfound ability to relate his experiences at school upon returning home. Both parents had noticed this new expressiveness. In addition to discussing it between themselves, they also mentioned it to Ernie. The father had also begun to discuss some of his worries at work with his wife. This was offered as further evidence of improved communication. Although Ernie was unaware of this, the

parents felt that this was a step in the right direction. They also felt that this was none of Ernie's concern.

As communication has become more direct and open within the family there was a clarification of the boundaries between subsystems. The improved flow of communication across boundaries allowed each family member to develop a clearer sense of self, and to begin to worry less about the others. In addition each new piece of information was met with openness by all family members, and its acceptance contributed to the reinforcement and amplification of this new pattern.

From one session to the next, there was also an observable increase in communication between Ernie and his parents. By the third session Ernie was openly challenging some of his parents' ideas. He was able to do this with humour and concern. Both parents were able to openly respond to his questions and comments, and showed great enjoyment in his new found abilities.

Ernie also believed that he would no longer be burdened with the belief that he needed to keep his ideas to himself. He felt that this would allow him to engage with others if any further feelings of depression occurred. Ernie also felt that his suicidal thoughts were a thing of the past, and did

not believe he would be troubled by these feelings again. His parents reported that they felt they were aware of the signs to watch for, and would not hesitate to directly question him if they felt that he was struggling at any time.

At this point both parents and Ernie felt that they had achieved their goal of more open communication within the family. They understood how the lack of communication had contributed to Ernie's inability to deal with his feelings, and did not see either arising again. A checkup appointment was arranged for five weeks later. It was agreed if the new behaviours had continued therapy would be terminated at that time.

At termination, the family reported a more open and direct communication pattern, and a more relaxed atmosphere. The mother also reported less frustration, and a reduction in her yelling and conflicts. Ernie, in particular, noted he is much more sure of himself, and more interested in school. He stated he was no longer concerned about being different from his peers. He explained that he now saw differences as acceptable, and he no longer was attempting to try and be just like other people, rather he just tried to be himself. The parents agreed with Ernie's views and were able to support his conclusions with observations of their own. They also noted

that they were having far more discussions between themselves than ever in the past.

When they were asked what had been they most helpful aspect of the therapy process, each identified the direct question to Ernie about whether or not he was suicidal. The parents noted that at the time they were shocked and could not have seen themselves asking Ernie directly. At termination both parents felt they would not hesitate to openly ask questions should Ernie appear depressed in the future. The use of this disclosure as an exception highlighted and promoted openness and directness for the family. At the same time this exception challenged the previous perception that family members would be overly hurt by direct communication. As a result of therapy the family saw themselves as having acquired the skills and abilities to confront and openly deal with any problems they might encounter in the future. They believed that shying away from each other had allowed the problem to develop in the first place and were committed to not allowing this to occur in the future.

In this case the evaluation instruments supported both the family's reports of change, and this writer's clinical observation. In the pre test family members scored between 56 and 67 on the overall rating scale. Of particular interest are the communication, affective expression and control scores

which range from 57 - 69, 55 - 68, and 56 - 66 respectively. The parents ratings in general and with respect to task accomplishment are worth noting. Both these scores illustrate their discomfort and general feelings of competence. Ernie's scores overall however do not illustrate the degree of discomfort and the severity of the problems he was facing. A full listing of the pre and post test scores can be found in table 2.

Table 2

Pre Test Results for Family M Using the Family Assessment Measure (FAM III)

Scale	Father	Mother	Son
Overall Rating	63	67	57
Denial	42	46	39
Social Desirability	41	46	39
Task Accomplishment	63	68	52
Role Performance	60	56	60
Communication	69	69	57
Affective Expression	68	63	55
Involvement	59	63	62
Conflict	66	66	56
Values and Norms	56	60	54

At the time of termination all scores were within the average range, as can be seen in table 3. The largest improvement can be seen in the scores of the both parents who for the most part fall in the middle of the average range. Ernie's scores at post test better reflected clinical impressions from interviews. At post test both parents also scored higher in both denial and social desirability. Ernie only scored higher in denial. It is suspected the success of the therapeutic process contributed to bias on the part of this family in terms of wishing to support how they now saw themselves, and not wishing to disappoint this writer. Figures 1 and 2 provide the pre and post test FAM III profiles, they were obtained approximately ten weeks apart.

Table 3

Post Test Results for Family M Using the Family Assessment Measure (FAM III)

Scale	Father	Mother	Son
Overall Rating	52	52	54
Denial	42	50	49
Social Desirability	49	55	41
Task Accomplishment	48	58	52
Role Performance	51	47	47
Communication	50	54	57
Affective Expression	54	49	59
Involvement	54	54	54
Conflict	51	51	52
Values and Norms	56	51	50

figure 1

Pre Test Profile for Family M Using the Family Assessment Measure (FAM III)

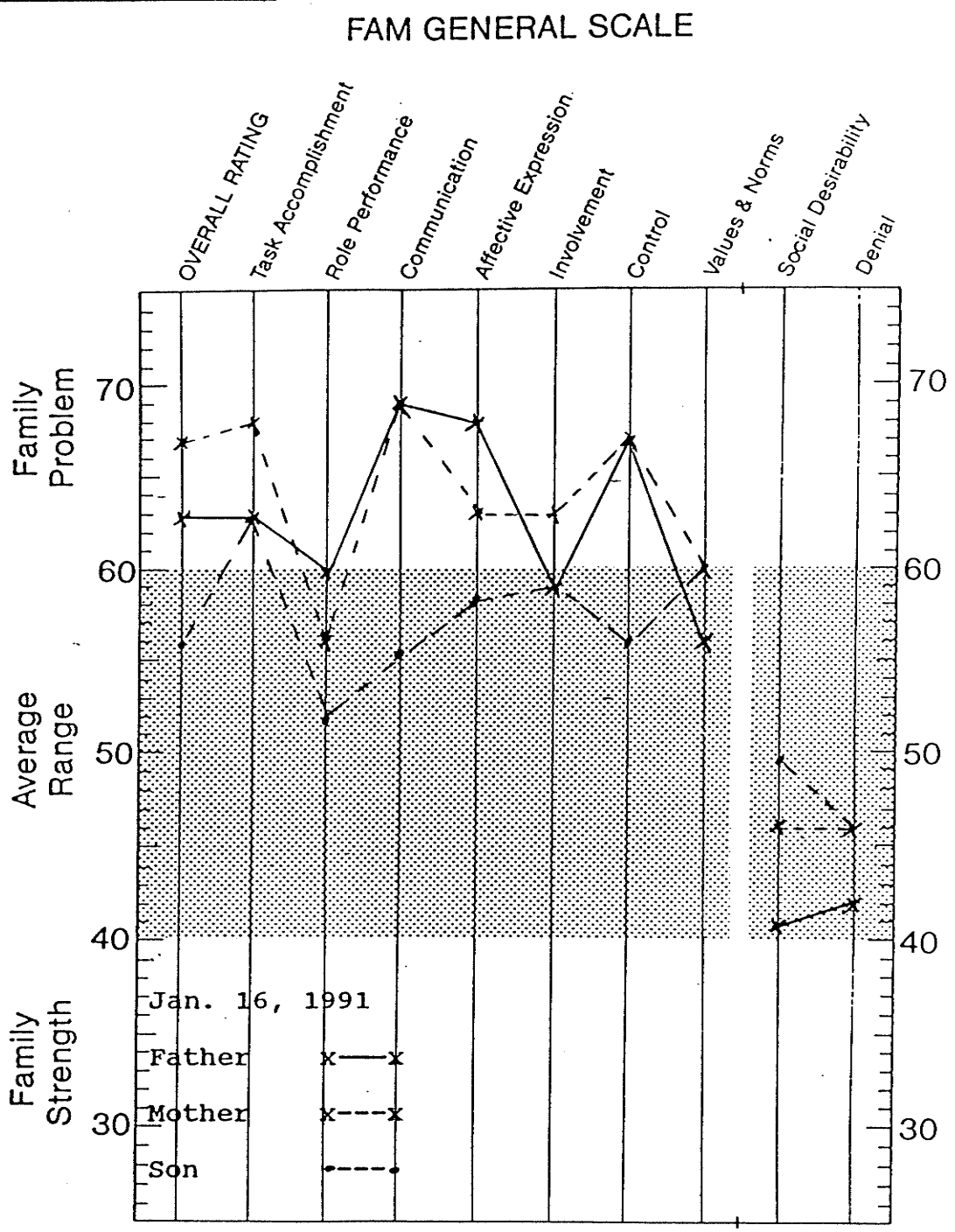
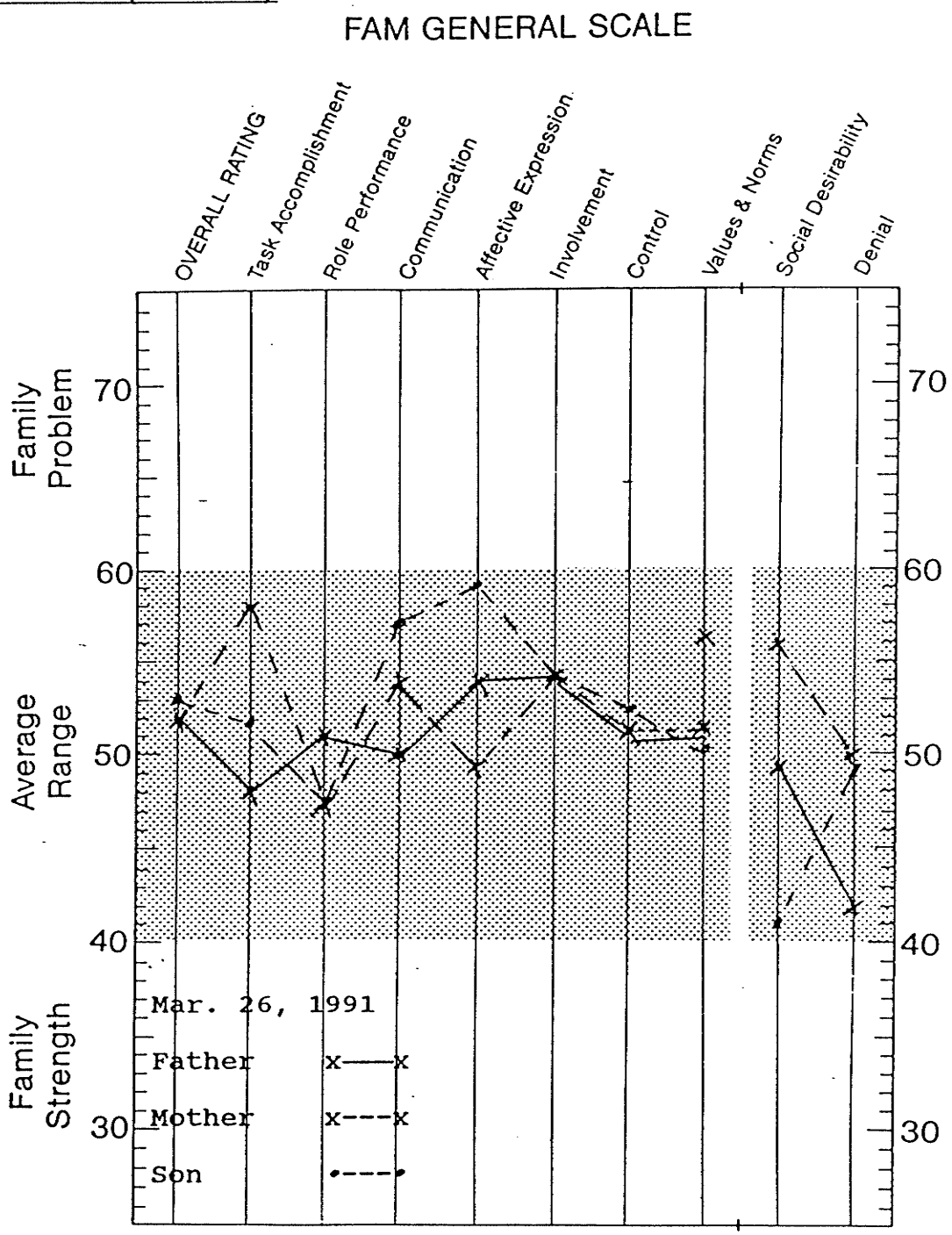


figure 2

Post Test Profile for Family M Using the Family Assessment Measure (FAM III)



The problem checklist showed similar improvements. It was administered three times in total. Initially Ernie rated himself mostly at the "in between" level. He did however feel dissatisfied with how rules were made, the amount of contact with friends, and how good he felt about himself. At termination each of these areas were rated at the satisfied level. Ernie progressed from feeling satisfied in 7 areas at the beginning of therapy to feeling satisfied in 18 areas. Five areas where rated in between. Of these five, three were related to affective expression and two were typical for adolescents.

The parents also showed improvements on this scale. The mother initially scored herself as feeling "in between" in 12 areas and satisfied with the rest. At termination she only rated two areas as in between, one was how anger and frustration was handled. In the remainder of the areas she rated the situations as satisfactory. The father initially identified feeling dissatisfied with sharing feelings and how anger and frustration were handled. Both these areas were rated satisfactory at termination. In addition he rated only 12 areas as satisfactory in the pre test. At termination, he felt he was satisfied with 22 of the areas, and only rated the situation and work as in between.

In conclusion, this case illustrated the use of identifying an exception and utilizing the exception in order to promote the development of a solution. For this family the first session and the direct questioning of Ernie was the intervention, and the utilized exception. Subsequent sessions served only to reinforce and amplify the changes which were already occurring. Both the evaluation instruments supported clinical impressions. The family did rate themselves higher than this writer's estimation. However this would seem to fit with their perceptions of the situation, and the initial pattern of wanting to appear in agreement, and avoiding conflict.

Case Example 2 - "It's not us, it was them!"

June O., contacted the Clinic to refer both her son Doug (15), and her daughter Sharon (12), for therapy. June was quite concerned about the amount of fighting and arguing which went on in the home. The conflicts occurred between herself and each of her children, and between the two oldest, Doug and Sharon. The conflicts usually occurred around household chores, and school work. June was tired of always fighting with her children, and believed that there must be a better way for them to live.

This single parent family consisted of the mother and her three children, Doug (15), Sharon (12) and Melanie (7). Each child had a different father. Doug never met his natural father. Up until last year he believed that his father was the same as his sister Sharon's. Contact with this man had been sporadic until two years ago when he began to have regular contact with them. In December, 1990 he discontinued his contact with the children. The mother believed that the children were quite upset by this turn of events. They receive no gifts, or even a card at Christmas time. She noted that part of the reason for the cutoff was her initiation of court proceedings to enforce child maintenance payments. She thought the children had been caught in the middle.

The family believed the majority of their problems resulted from the time they spent with Melanie's father. This man was described as being violent and controlling towards June. He was not physically abusive towards the children. In 1988, June left Melanie's father. This man was unwilling to accept of the dissolution of the marriage. He had harassed and threatened the family repeatedly after the separation. He was killed in a work related accident six months after the separation. The family believed that he would still be harassing them if he was still alive.

During the first session June also disclosed that she experienced sexual abuse during her childhood. She also disclosed experiencing physical and emotion abuse at the hands of each of her children's fathers. In the spring of 1990 she had sought therapy for her family. She recounted that only she attended, and had found therapy helpful for resolving her own personal issues. She felt it was time for her family to resolve their problems.

In September 1990 the family moved closer to Saskatoon. June secured herself a new job, and all three children began new schools. For the last two years, June has also taken night courses. She expected to complete her certificate over the next three years.

Ms. O presented as a very competent, intelligent, and strong mother who was deeply concerned for her children. She noted how frustrating she found the situation at home, and that she had no idea how to deal with the children's behavior. Both Doug and Sharon who attended the sessions appeared quite committed to the mother, and very unhappy about the conflicts and tension in the home. They appeared to be interested in and committed to discovering new ways of dealing with their problems.

The family described the problem in the following terms. Ms. O worked Monday to Friday from approximately nine to six-thirty. She had to rely on the children to look after themselves until she gets home, and expected their help and cooperation in most matters. Doug saw himself as being in charge of the family when his mother was at work. He would try to get Sharon to do her chores, but was often not successful. He would attempt to discipline her, and a fight would develop. Ms. O would return home to find Sharon waiting for her at the door, and a fight would then develop between Sharon and her mother over her chores. Regularly, further conflicts would develop between Doug and his mother regarding what had occurred prior to her arrival home. The family described how almost every evening would be spent in conflict, and that by the end of the night the tension would seem unbearable.

The family identified the constant conflicts as the major problem. The mother also identified the lack of assistance around the home as her major source of frustration and anger. One exception was quickly noted. It seemed that whenever they went on a vacation or family outing the problem was either nonexistent or significantly reduced. They felt this was because they would join together to have a good time. June also thought it was due to the lack of chores or

responsibilities. Activities were cancelled when chores were not completed.

This was a family which had been strongly influenced by their experiences of physical and emotional abuse. It appeared that in the past they had been organized by the common threat and had drawn together in order to protect each other. The hierarchy had been ruled by the fathers, and a rigid boundary had existed around the executive subsystem. June and her children all belonged to a subsystem excluded from power in the hierarchy. Each had developed a rigid boundary as a defence when conflicts and tension arouse.

Doug was perceived as acting as a parentified child, who lacked the authority to carry out the role. The mother had attempted to encourage her children to assist her. She hoped that through explanations they would understand and take responsibility. She would accommodate them until her frustration grew and she became angry. There was a lack of an executive subsystem and a lack of clear boundaries. The level of conflict, frustration, and anger led to a very disengaged style of interaction with rigid boundaries between members. The problem was exacerbated by Doug's parentified role.

The family members agreed to a contract for up to five sessions. The goal was to reduce the number and intensity of

conflicts. Each was complimented for their honesty and interest in resolving the problem. It was suggested that they had all been influenced by their experiences in the past and how others had "bossed them around", and treated them unfairly. It was further suggested that each had a strong sense of justice. When they felt they were unjustly treated they reacted strongly. Two tasks were assigned. The family was asked to notice how they were acting when fights were not occurring. Doug was also asked to try to not boss his sister around.

The second session began with the mother reporting that she noticed conflicts only occurred when she made requests of her children. She also noted that Doug ceased to attempt to boss his sister, and there had been fewer fights between Doug and his sister Sharon. Conflicts continued to occur between the mother and Sharon or Doug.

The family members recognized that each expresses anger in a way which distanced them from each other. This behaviour was framed as being functional in the past, as it had afforded each of them protection from abusive situations. It was suggested that each of them had continued to be influenced by their experiences with persons who are no longer part of the family. A discussion was held about how they had been influenced by the anger of others. It became clear that in

the past, anger had trained them to react rather than think. June became very interested in the idea that their problems and behaviours were a result of their past training and experience. She had perceived that the problem resided within the family. As she put it "I always thought it was something inside us". The idea that there was nothing "wrong" with her or her family was a freeing idea that opened up space for her to perceive the problem differently.

Thinking before taking action was highlighted using two exceptions. The first was Doug's reduced "bossing" of his sister. Doug noted that he had begun to think before he spoke and thought that this had led to fewer conflicts. A second exception highlighted Sharon's recently improved school performance. Sharon identified her own thinking as the cause. She noticed that when she did her homework and paid attention in school, she did better and avoided conflicts with her mother. Both children were complimented on their astuteness, intelligence, and discipline. The conflictual behavior in the home was described as a family tradition which had been harmful. The changes were depicted as steps towards the creation of a new family tradition of health. Because thinking had been helpful, the family was requested to attempt to think before they spoke, especially when a conflict was beginning. It was explained to them that this was a way of responding to a situation in a manner that they could live

with as opposed to reacting in the manner they had been trained to by others.

At this point, Doug had begun to remove himself from a parentified position, and this opened up space for the mother to directly deal with her daughter. During this session it was noted that a boundary had begun to develop around the sibling subsystem. In the home, the mother had also begun to assert herself in the executive subsystem.

By the third session the family members reported that there had been only two conflicts in two weeks. One of these occurred between Sharon and her mother, but lasted only twenty minutes rather than the whole evening. The second occurred when the mother became frustrated at Doug and Sharon's inattentiveness. Both children described how they decided that they would listen to their mother as opposed to fighting with her. June had also noticed that during the last two weeks both Doug and Sharon had been quite responsible with their household chores. Doug had even been cooking dinner regularly, and he and Sharon were being much more cooperative with each other.

June believed that she had been successful in attempting to think before she spoke, and found that when she did so she felt clearer, and was able to set consequences that she could

readily enforce. She had been able to avoid feeling frustrated and taken advantage of, and was much happier with this type strategy. Doug continued to not "boss" his sister, and was finding relief through not taking responsibility for her behaviour. Sharon had discovered that she could be responsible, and was able to discipline herself to do her chores when she got home, rather than avoid them.

The family had worked very hard between sessions. Clearer boundaries and a more appropriate executive subsystem continued to develop as a result of successfully tackling the problem. The family moved from a system with disengaged individuals with a diffuse boundary around the family to one with clear boundaries both within and without. At this point family members felt that they had achieved their goal. A termination appointment was scheduled for two weeks time. The family was requested to plan a celebration for themselves in order to highlight the changes they have made.

June O, and her two children attended a termination and follow-up session five weeks after the first appointment. The changes had continued, and there had been a significant reduction in the frequency and intensity of their conflicts. There had been some minor difficulties during the interval between session. June had recognized that these were slips, and found that they were quite easily rectified.

Although the family members still felt they had some work left to do, they did not believe they required further therapy in order to achieve this. They felt that therapy had assisted them in identifying the direction they wanted to follow, and they now were able to recognize their abilities and competence that could be used to complete their task.

The evaluation instruments supported the clinical observations and conclusions. The initial FAM III profile (Fig 3) provides a clear picture of the different areas each member found most problematic. June was most disturbed by the situation and as a result had the highest profile. Communication, affective expression, involvement and control all fall in the family problem area. Doug's score highlights involvement, while Sharon's records task accomplishment as a weakness. It should be noted that June's scores in the social desirability and denial scales fall below forty and thus call into question the validity of her profile (Skinner et. al., 1984). Each person's perception of the problem does appear in the profile. At the time, given the past history of the family, this profile was taken to indicate the existence of significant strengths and competence since the profile does not indicate extreme weaknesses, in any area. A complete breakdown of the pre test FAM III scores can be found in table 4.

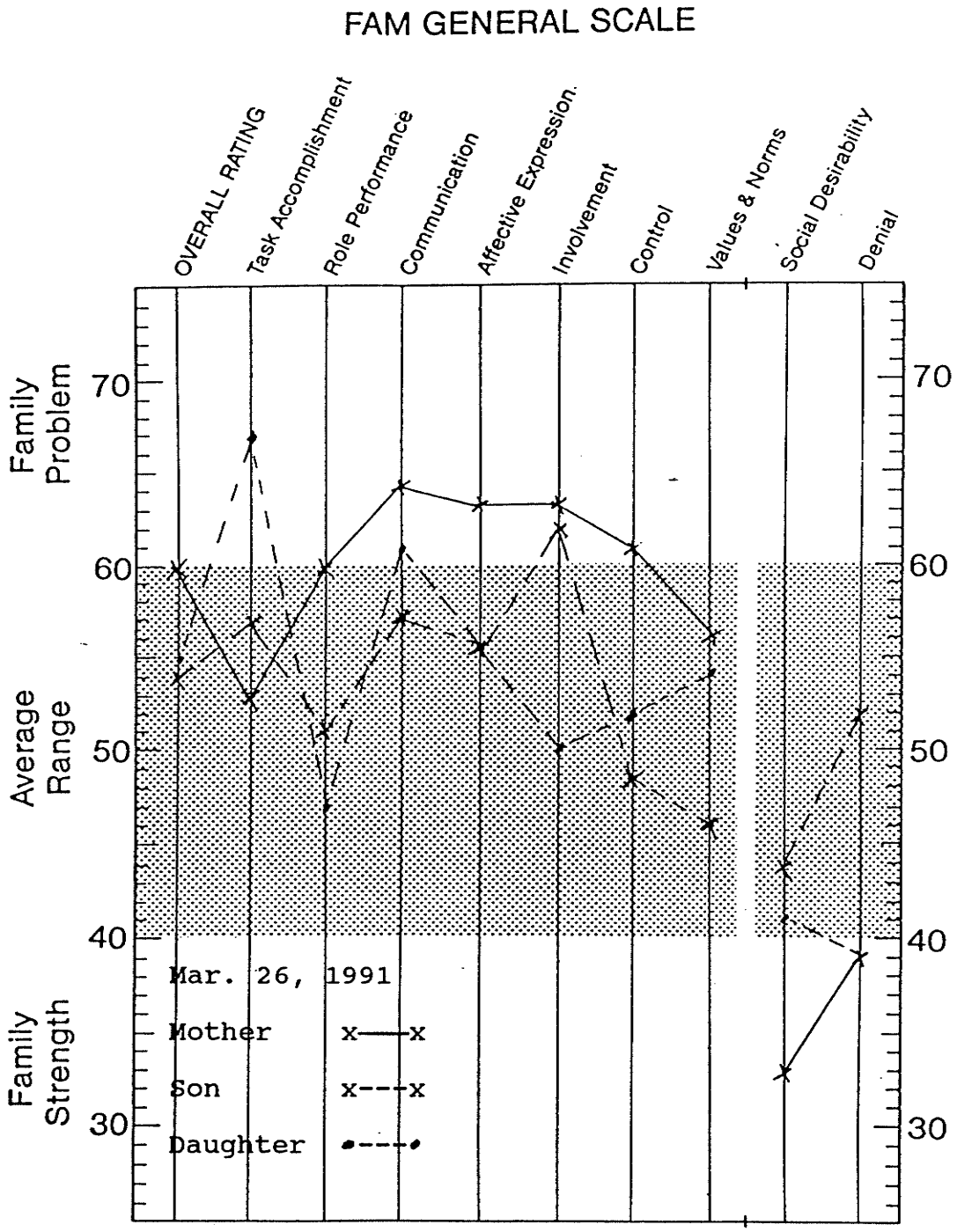
Table 4

Pre Test Results for Family O Using the Family Assessment Measure (FAM III)

Scale	Mother	Son	Daughter
Overall Rating	60	54	55
Denial	39	52	39
Social Desirability	33	44	41
Task Accomplishment	53	57	67
Role Performance	60	51	47
Communication	64	57	61
Affective Expression	63	55	55
Involvement	65	62	50
Conflict	61	48	52
Values and Norms	56	46	54

figure 3

Pre Test Profile for Family O Using the Family Assessment Measure (FAM III)

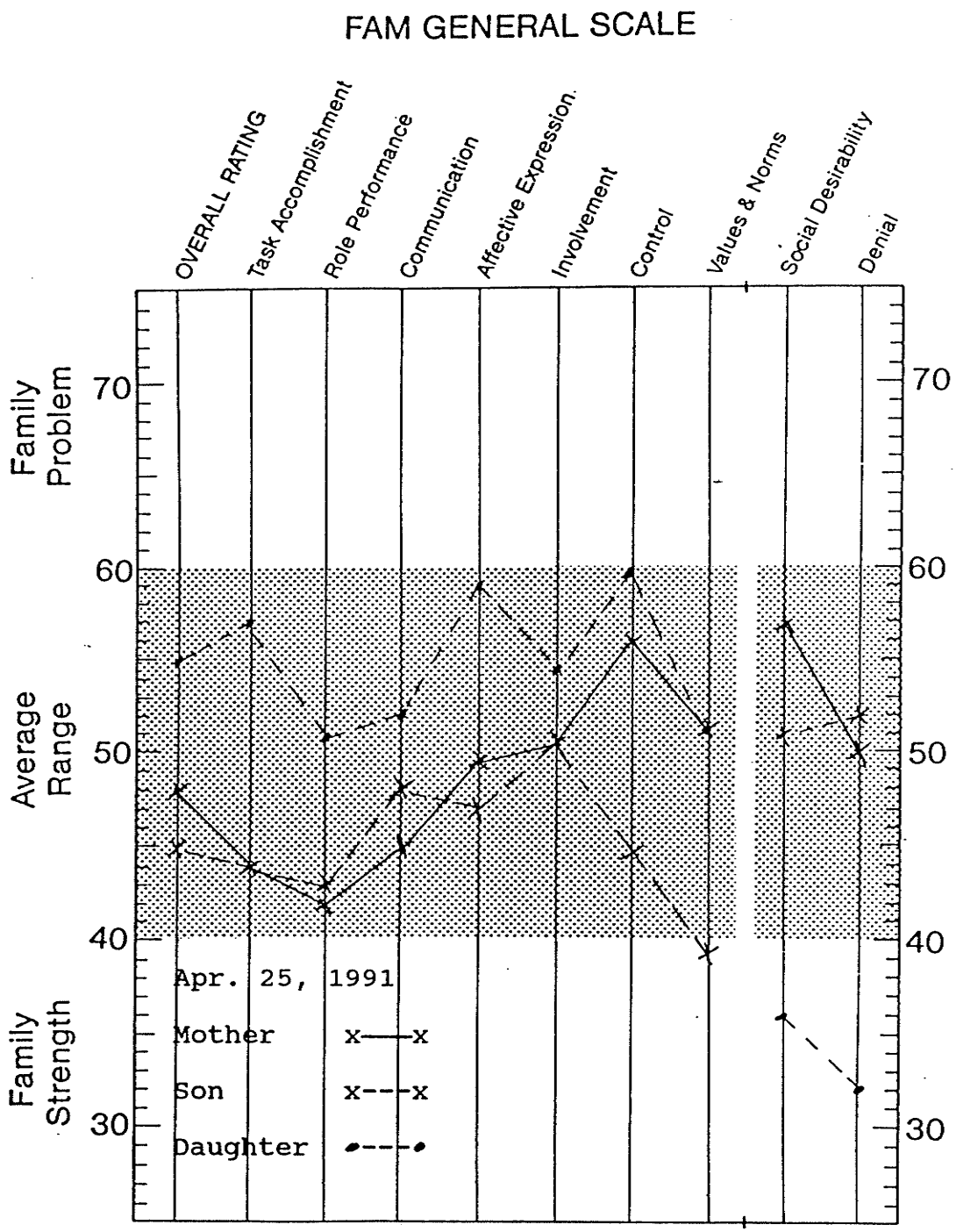


The initial problem checklist also supports the mother being most concerned and bothered by the problem. Four areas related to affective expression and involvement were rated as dissatisfied. Relationships between parents and between parents and children were rated dissatisfactory as well. The relationship between the children was rated at very dissatisfied. Doug rated nine areas in between, these included the same areas as his mother plus independence and contact with friends. Sharon identified herself as feeling dissatisfied with how anger and frustration were handled and the situation at school. The problem checklist complemented the initial FAM III profile, and clearly identified where each member was most concerned.

A little over four weeks later, significant differences can be found in both the FAM III profile (fig.4), and the problem checklist. All FAM scores were within the average range. Of note is the change in the social desirability and denial score of the mother. Because it exceeds 50, the validity must be questioned (Skinner et. al., 1984). It is speculated that because the changes were so quick there was still some uncertainty regarding the durability of the new family pattern. It is also suspected that the success of therapy and the relationship between the family and the therapist influenced the mother in particular to answer in a manner

Figure 4

Post Test Profile for Family O Using the Family Assessment Measure (FAM III)



that complimented the therapist. It is believed a future profile would better highlight this parent's strengths and abilities. A full listing of the post test FAM III scores can be found in table 5.

Table 5

Pre Test Results for Family O Using the Family Assessment Measure (FAM III)

Scale	Mother	Son	Daughter
Overall Rating	48	45	55
Denial	50	52	32
Social Desirability	57	51	36
Task Accomplishment	43	43	57
Role Performance	42	43	51
Communication	45	48	57
Affective Expression	49	47	59
Involvement	50	50	54
Conflict	56	44	60
Values and Norms	51	39	50

The problem checklist supports the improvements noted clinically and by the FAM III profile. All areas initially rated by the mother and daughter as dissatisfactory or worse

were rated at the satisfied level by the end of therapy. Doug also rated the majority of areas as satisfactory. The only exceptions were six areas rated at very satisfied.

This was a family which responded extremely well to a solution focus. Both children and the mother found that the strengths which were highlighted to be new information about themselves and their abilities. During the evaluation of therapy each was able to note what had made a difference for them. Doug had found relief from discovering that he did not have to take responsibility for his sister's behavior. Sharon found the suggestions on how she could use her abilities from other areas to be very helpful. June related the relief she experienced in understanding that the problem was from the past and had served to protect them. The family members also found that as a result of their experience they had a strong sense of what they each needed to continue to do in order to maintain the changes. From a clinical perspective the last session served to highlight the changes that occurred in the family structure. During the first session it was noted how each answered questions for the others, and how diffuse the boundaries were between all members. During the last session, up to a minute of silence would occur as one person thought on the answer the question posed at the time. No longer was there the need to look towards someone else in the family, nor was there the need to be in complete agreement. At

termination, family members felt they had broken with the past, and were in the process of creating a new family tradition which promoted the health and competence of the individuals and the whole.

Case Example 3 - "He's got to learn to control his anger"

Maureen N called to refer her natural son, Sid (15), for counselling. According to the parents when Sid got angry he exploded, slammed doors, and threw his personal belongings around in his room. Both parents were concerned about these instant blow-ups which occurred whenever Sid was displeased. Sid was perceived as always lying. The parents had noted that these blow-ups often occurred when Sid was confronted about statements he made.

This blended family of eight years had two children, Sid, who is from the mother's first marriage, and John (4) who was a product of the present union. Sid's mother, left her first husband who was physically abusive when Sid was seven months old. Sid reconnected with his natural father two years ago and spent one weekend a month with him. The family members did not see this as related to the problem. However, they did wonder whether Sid had inherited his father's temper.

Sid, his mother, and his step father, attended the first session. Maureen presented as an intelligent and competent parent, who was concerned about her son's temper and his habit of lying about the smallest of things. According to Maureen, she had been the primary disciplinarian as Sid was her natural child. She felt that Jim could be quite verbally mean when he and Sid got into a conflict. Maureen believed that she needed to protect Sid from his stepfather, and continually monitored their interaction. At the same time, when she did confront Sid on his behaviour, he would often lie. She found this quite frustrating, and would lose her patience with him. All family members agreed that when this occurred Sid lost his temper, and could become verbally abusive. He would also go to his room where he would yell and scream. At times he would destroy his own possessions.

Jim, a rather shy man, thought that he acted as a somewhat detached stepfather. He believed Sid's lying was manipulative, and felt that he had to always be on guard against feeling taken advantage of. He agreed that when he got angry or frustrated he could be quite verbally vicious. He also saw this as a problem but had not yet succeeded in dealing with it. The family members identified the relationship between Sid and his stepfather as problematic. Jim thought he had never clearly defined his role, and tended to leave discipline to his wife. Jim also felt that he did

not love Sid; he thought he would like to have a better relationship with him.

Sid presented as a likable, and intelligent boy of 15. He saw the problem as his parents' desire that he learn to control his temper. He thought this was a problem only some of the time. He stated that he did not enjoy being mad and would like to learn how to control his temper. He noted that when his parents remained patient, he found it easier to control his own temper. He confirmed that he did lie frequently. He saw this as one of the major sources of arguments and was not sure why he did so. He felt he lied about 75% of the time, and recognized that it was mostly about little things such as whether he had done his homework, when he had a test, etc..

It was clear that each member of the family had done a considerable amount of thinking regarding their involvement in the problem. Each member was able to identify their own behaviours with which they were unhappy. Both parents and Sid appeared committed to resolving the problem. Through the initial discussion it was clear that the lies were strongly linked to the presence of the problem. In addition they were having a negative influence on the relationships between family members.

After thoroughly discussing the situation, family members were beginning to sound discouraged, and frustrated. It was recognized that there was a need to move away from the problem and begin to project the family into a more positive future. The "miracle question" was utilized in order to both instill hope, and to assist in the development of a clearer picture of what the future would look like when the problem was resolved.

Maureen answered first. She thought Sid would be more accepting of their decisions. She also thought Sid might begin to offer information about his day, without her having to pry. Maureen envisioned a future in which Sid and Jim might be found discussing the events of the day, and saw Jim being more interested in Sid's activities. Maureen believed this would lead to a reduction in tension around the home, and she would feel less protective of Sid when Jim was with him. She also thought she would be less suspicious of Sid lying.

Sid followed his mother by responding that he thought he would spend more time upstairs with the family. He would not try to avoid conversations, and he would be able to control his temper. He also thought he and his stepfather would spend more time together. Sid thought he would feel he could talk about anything, and Jim would be more interested in what he was doing.

Jim also saw the relationship between Sid and himself improving. He thought he would be talking more with Sid, and that he would not feel the need to monitor Sid as closely. Instead, Jim and Sid would be doing more activities together. He also thought he and his wife would be spending more time together. He thought the first clue that the miracle had happened would be that he and his wife would talk at breakfast time. Jim also noted that he would be seen as a more pleasant person.

The miracle question helped the family to identify the problem as occurring most often between Jim and Sid. As a result it seemed appropriate to look for exceptions to the problem in this relationship. It quickly became apparent that Sid and Jim could identify many exceptions. They both described attending hockey games together, sailing, and nintendo as times they get along well. In addition Jim noted that at those times he is not suspicious of what Sid is telling him. When asked what was different at those times, they noted that Maureen was not present. Further exceptions were found between Maureen and Sid. They both were able to identify times when they got along, and when Maureen was not suspicious of what he was telling her.

Maureen recognized that she often tried to get to the bottom of situations with Sid by herself, in order to protect

Sid from Jim. When she became angry and frustrated Jim would come onto the scene and support her. She noted that when Jim and Sid argued she would often feel that she needed to defend and support Sid.

By this point a fairly clear assessment of the problem was determined. The family appeared to have developed a triangulation pattern which detoured conflicts on to Sid. There was an overinvolved relationship between Sid and his mother, and a conflictual relationship between Sid and his stepfather. Although the parents presented as a united front, there appeared to be unresolved conflicts in the marriage. At the time the problems with Sid assisted the parents to draw together, and promoted a shared focus on the identified problem.

Sid's behaviour, particularly the lying could be understood as his attempts to avoid conflicts with either of his parents. Because this behaviour occurred so often it served to increase the conflicts, and promoted and stabilized this pattern of triangulation.

The family members agreed to a contract for up to five sessions. The goal was to eradicate the pattern of lying, and to assist Sid in gaining control over his temper. In addition family members agreed that an improved relationship between

Jim and Sid would be of beneficial. The goal of treatment was to promote the clarification of boundaries both around the marital subsystem, and between the parental subsystem, and the sibling subsystem. Prior to ending the session each was complimented on their honesty, and commitment to eradicating the problem. An appointment was set for two weeks time. The family was asked to notice what they themselves were doing when things were going well at home.

Therapy in this case was completed in four sessions over a period of five weeks. The family members arrived for the second session reporting that the situation had been somewhat improved since the first session. The mother noticed that when she controlled her own behaviour, there was an improvement in the relationship between her and Sid. As a result she had been attempting monitor her own actions rather than attempting to control Sid's. Jim stated that he had been somewhat more relaxed but he still felt on guard against Sid's manipulations. He noticed that there had been no conflicts. When he was asked how he accounted for this he thought it was because they had all been very busy. Upon further reflection he noted that they were usually busy and this had not reduced conflicts and lies in the past. Sid declared that he had tried to control his anger, and had thus far experienced a fair amount of success. The task assisted family members to begin questioning their previous definition of the problem.

They were unable to relate the past two weeks within the worldview they held and had begun to explore new information about each other and themselves.

The remainder of the session focused on the one conflict which occurred between Maureen and her son. Sid was able to identify that when he does argue with his parents, he feels misunderstood. He recognized that he repeats himself over and over rather than trying new ways to explain his feelings to his parents. Both parents complained about always trying to guess what Sid meant, and of suspecting him of attempting to manipulate them. They parents came to an understanding that when a conflict occurred with Sid, they attempted to figure out what he was thinking. It was suggested that engaging Sid in this manner reduced his ability or need to explain himself, or figure things out for himself. Throughout the session an effort was made to continue to validate, support and compliment each member of the family as they struggled to develop a new understanding of the problem.

In discussing the different types of conflict with the family it was clear that an enmeshed boundary between Sid and his mother, and a conflictual one between Sid and his stepfather existed. Where as Jim would join with Maureen against Sid, Maureen tended to protect Sid against Jim. Although Maureen had begun to question how she related to her

son, there was yet no change in the relationship between Sid and stepfather Jim.

A third appointment was scheduled for two weeks time. The parents were instructed to no longer guess what Sid meant by his statements. They were instructed to not go into long drawn out explanation of the consequences. Rather they were to try and accept Sid's statements at face value, and allow him to deal with the consequences.

By the third session there had been only one conflict. The parents were still unwilling to accept this as a sign of change. All family members had given a great deal of thought to the one conflict which had occurred, as it had culminated with Sid threatening to go live with his natural father. Maureen rather than arguing and attempting to convince Sid of the error in his thinking, had allowed him to think about this action. The next day Sid informed her that he does not wish to leave the household. They were able to discuss the preceding argument and resolve it in a new manner.

This incident was highlighted as an exception. It was suggested that once Sid did not feel that he had to fight for how he felt, he was forced to think about the situation and come to a decision on his own. Sid was complimented on his

ability to make good decisions, and the parents were complimented on their ability to let him do so.

The parents were also able to note the progress Sid had made in recent months with his school work, and how they had received compliments from other parents regarding Sid's behaviour. Sid was surprised at this information, and was quite pleased that it had been noticed. The differences and difficulties of raising a four year old and a sixteen old at the same time were also introduced as a means of normalizing some of Sid's behavior. The parents began to recognize that they sometimes treated Sid in a manner similar to his four year old stepbrother. Both parents became aware of the difficulty they were having letting go of Sid and the level of control they were accustomed to holding. They further recognized how this desire for control may have contributed to the development of the problem.

Significant change had also occurred in the relationship between Sid and Jim. Jim had been quite affected by Sid's threat to leave home, and was perceived by both Sid and his mother as acting in a protective manner towards Sid. Both Sid and his mother had noticed how visibly upset Jim became at the thought of Sid leaving. They were able to accept this new picture of Jim, and as a result there was a decrease in the

distance between Sid and his stepfather. Maureen also felt much less of a need to protect Sid from Jim. A fourth appointment was scheduled for two weeks time. As the internship was to be concluding then, family members were asked to decide whether they felt therapy should be terminated or if they wished to have their file transferred to another worker.

Two weeks later, the family members felt that termination was appropriate. Although they felt they still had some work left to do, they believed they were at a point where they would be able to complete the changes on their own. Only one conflict had occurred over the last two weeks. Each was able to report what they had done differently to encourage the reduction of conflicts. Maureen had continued to monitor her own reactions. She had succeeded in withdrawing when she felt she was getting to frustrated. This also allowed her to more clearly identify what she wanted to achieve. Sid reported that he had continued to attempt to think about what he said, and had begun to take responsibility for his own behaviour. Jim had attempted to be less reactive, and in particular was trying to allow Sid to take responsibility for his actions, rather than trying to direct him to do so.

Each member noticed that the home environment was less stressful. In addition Sid had noticed there was much more

conversation between members, especially between himself and Jim. This was supported by Maureen who saw a reduction in her own apprehensiveness regarding interaction between their interactions. She further noted that she no longer noticed when they were together.

The family members felt that the problem that brought them into therapy had been resolved. The initial problem had been redefined. Each now saw that they had some responsibility towards its development, and each has a part to play in maintaining the solution. All family members felt that they had benefited significantly from the therapy process, and were confident that they could continue the changes on their own.

The evaluation instruments supported the clinical observations and conclusions about this family and the positive outcome of therapy. The initial FAM III profile (figure 5) illustrates the severity of the problem they perceived. A complete account of the pre test scores can be found in table 6.

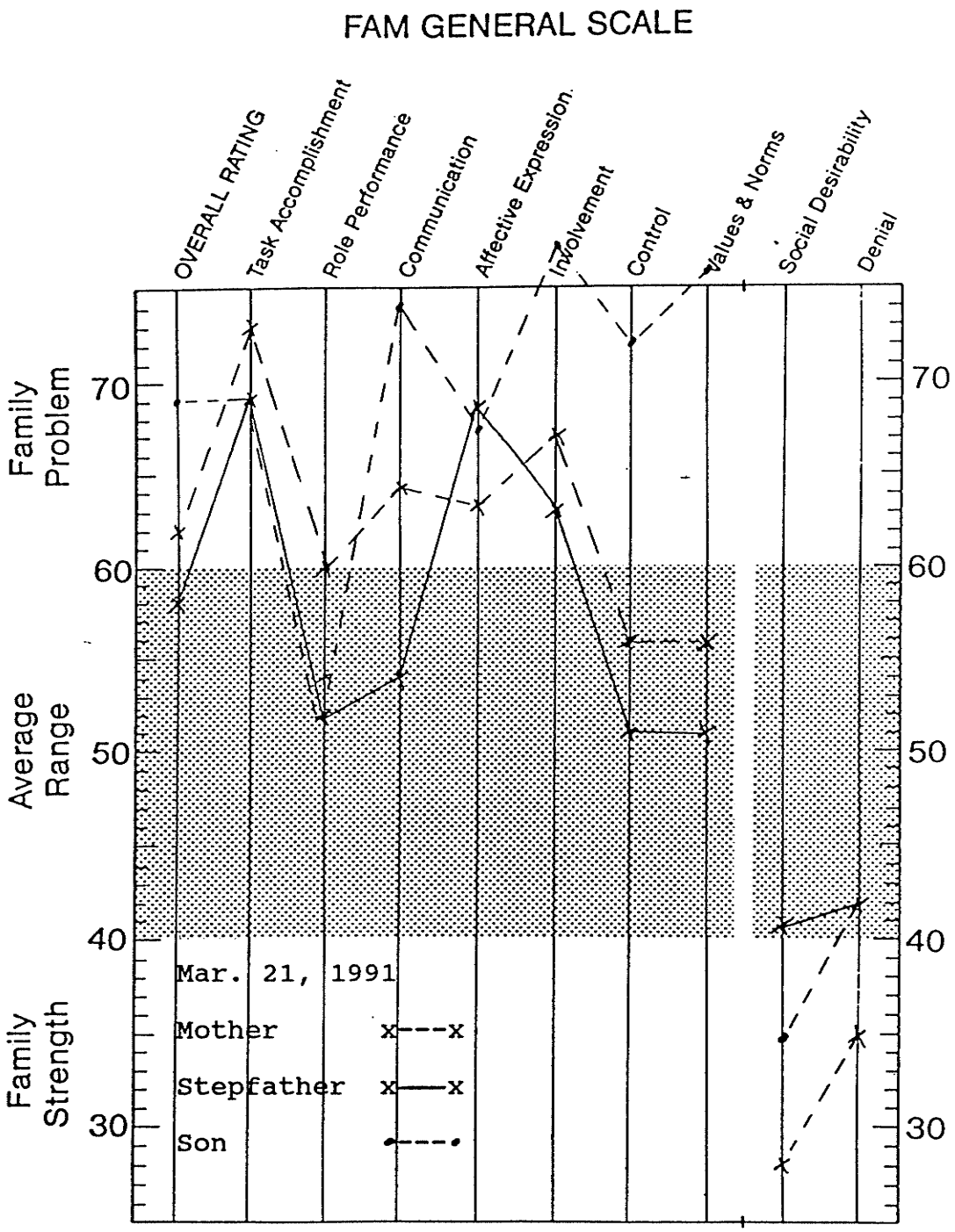
Table 6

Pre Test Results for Family N Using the Family Assessment Measure (FAM III)

Scale	Father	Mother	Son
Overall Rating	58	62	69
Denial	42	35	42
Social Desirability	41	28	34
Task Accomplishment	68	73	67
Role Performance	51	60	51
Communication	54	64	74
Affective Expression	68	63	68
Involvement	63	67	78
Conflict	51	56	72
Values and Norms	51	56	76

figure 5

Pre Test Profile for Family N Using the Family Assessment Measure (FAM III)



Overall ratings ranged from 58 to 69. Maureen registered in the problem range in the areas of task accomplishment (73), communication (64), affective expression (63) and involvement (66). Each of the areas support both the clinical assessment and Maureen's initial descriptions of the problem. It should be noted that Maureen scored below forty on both the social desirability and denial scales. This may reduce the validity of the profile (Skinner, et. al. 1984). Jim's scores support his wife's. Affective expression is somewhat higher (68), and communication (54) is not identified as a problem area. Task accomplishment (68), and involvement (63) are both seen as problem areas. Again his description of the problem is supported by his profile. Perhaps the most severe scores are Sid's, who identifies the same areas as his parent; task accomplishment (68), communication (74), affective expression (67), and involvement (78). Sid's profile also identifies control (72) and values and norms (76) in the problem area. Sid's scores on the social desirability scale suggest these may be somewhat exaggerated. At the same time it did offer a reasonably accurate picture of how he was perceiving the family at the time.

The post test scores (Table 7) and profile (figure 6) show the dramatic changes in how the family perceived the situation. By the end of therapy all scores were within the average range. Of particular note are the scores for all

members in the areas of task accomplishment and affective expression. Both the mother and Sid scored significantly higher on the social desirability scales in the post test period. This was a trend that was noticed in a number of cases. It is assumed to be related to the development of the therapist - family relationship.

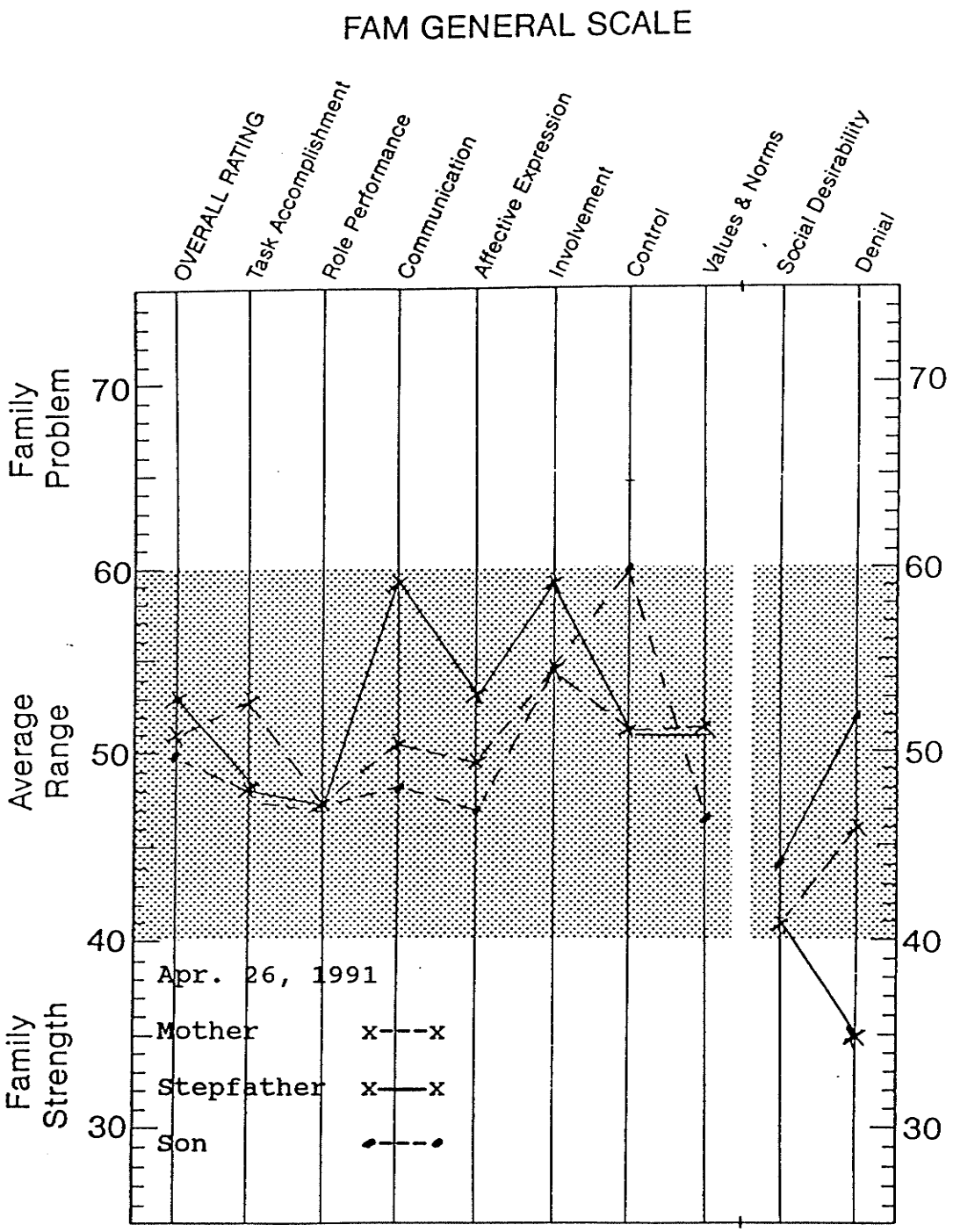
Table 7

Post Test Results for Family N Using the Family Assessment Measure (FAM III)

Scale	Father	Mother	Son
Overall Rating	51	53	50
Denial	46	35	52
Social Desirability	41	41	44
Task Accomplishment	53	48	48
Role Performance	47	47	47
Communication	50	59	48
Affective Expression	49	54	47
Involvement	54	59	54
Conflict	51	51	60
Values and Norms	51	51	46

figure 6

Post Test Profile for Family M Using the Family Assessment Measure (FAM III)



The problem checklist was more useful in this case, than with other families. Each member of this family rated themselves very dissatisfied in one area the first time the checklist was used. Maureen identified how anger and frustration were handled, Jim identified showing feelings like happiness, joy and pleasure etc., and Sid identified the amount of independence he had. Each of these corresponds directly to how and what the individual in question viewed as the problem. At termination each person identified feeling satisfied in each of the areas previously mentioned. In addition, at the beginning of therapy, Maureen and Jim identified feeling satisfied in 10 areas, while Sid identified 13. At termination Both Maureen and Sid felt satisfied or better in 21 of the 23 areas, while Jim scored 17 areas satisfactory or better. Although the problem checklist does not have the validity of the FAM III scale, in this case it provided a strong complementary and problem specific measure.

This case is perhaps the best example of how a solution focus can be combined with a structural assessment and understanding of the family's interaction. From the outset a clear assessment was made of the structure, with a specific focus on the boundaries between and within subsystems. The solution focus directed the problem to be defined within the family's worldview. The focus of therapy was to expand the worldview by encouraging each of the family members to observe

their interactions within a climate of support and acceptance. Once a rapport was established and maintained, each member was open to questions which highlighted differences. One of the major exceptions used during the therapeutic process was their regular reports of only one or two conflicts between sessions. The family twice attempted to explain this to be as a result of their busy schedules. However, the question of why there were fewer conflicts than they had previously experienced, remained relevant throughout therapy. In addition, the first session highlighted the exceptions that Jim and Sid could get along. This called into question the view that they only had a conflictual relationship. The instruments used to evaluate the outcome supported both the clinical assessment and the outcome as described by the family. In particular the instruments reflected the changes in how family members perceived both themselves and the problem at the point of termination.

Chapter 6 - Conclusions and Summary

Evaluation of the Practicum

This practicum provided family therapy services to fifteen families over the course of four months. Treatment for two of the families was considered unsuccessful, as they dropped out of therapy. Follow up telephone calls to both families did, however, result in reports of positive changes. One mother (family A) felt she had achieved her goal. Clinically, this was not felt to be a lasting solution. Nine of the families seen felt that they had accomplished and reached their goal. The maximum duration of therapy was four sessions for eight of these cases. The briefest was only two sessions. Four cases had not been completed by the conclusion of the practicum. Each of the four families was interested in continuing therapy as they had made some progress. These were transferred to staff at the clinic.

Overall, the practicum was a positive experience for both this writer and the families that were seen. The model of therapy utilized was effective in nine of the situations encountered. Not surprisingly the unsuccessful and transferred cases were the most difficult of the fifteen. They did provide valuable learning opportunities and experiences.

It is clear that the solution focus is a useful and effective model of therapy that often promotes rapid change. Clients often found the sessions to be quite enjoyable, and a few commented on how much they looked forward to the meetings. During the practicum it was noticed that clients had begun to say thank you at the end of the session. This happened on quite a regular basis. Since returning to work this has continued to occur regularly. In fact it has now become the exception when it doesn't occur. This behavior corresponds with some of the feedback received during the consumer evaluation regarding how the clients found the experience. Clearly the solution focus is a very respectful and validating method of therapy, and clients responded highly in its favour.

It is also worth noting the situations that existed in the cases that required the most sessions and transfers. Two of these involved issues of abuse. The first was a 16 year old who had been sexually abused by her sister when she was 9. She had never disclosed to her parents, and had left home in September 1990. Just prior to this writer concluding the practicum she found the courage to disclose the abuse to her parents. The last session was the first time her parents attended. The session provided an alternative explanation to the parents and the client of their experiences and understandings of each other over the last six years. The parents also contracted with the new worker for family

treatment specifically to address the abuse and the eldest daughter's sexual offending behavior.

A second case included a mother with a history of severe physical and emotional abuse as a child, and three battering relationships. Treatment attempted to assist the mother with her own personal issues, and solve the conflicts between her and the daughter. At the time of termination there had been significant improvements in the home situation. However both the mother and the daughter felt apprehensive about concluding their therapy so soon after the changes begun.

It would appear that there are some cases that cannot be concluded within as brief a period as others. Those in which there is long history emotional and/or physical trauma require a longer period of time in order for the survivors to recover and heal from their pain. A second factor which was common to all the cases which lasted for more than four sessions was the degree to which the family or an individual in the family felt joined by the therapist. This was a combination of trust needing to be more fully developed, and error on the part of the therapist. It is believed that the solution focus shortened the duration of therapy in all the cases seen during the practicum. One can offer the distinction that although therapy may not have been as brief as four to six sessions, it was briefer than this writer had previously experienced. It

is speculated that the solution focus shortens the duration of therapy in the vast majority of situations.

In general, it is believed that those cases which were not successful, were more a result of this writer's skill level than the limitations of the model. The use of structural concepts provided a sound method for classifying and organizing information provided by the families. Regular assessment of the family structure allowed for a clinical interpretation of the changes as they occurred. This was utilized to both track progress and lead towards a future that did not include the problem. The solution focus, when it is truly accepted, makes it quite difficult to view clients in a negative light. Identifying what the future will look like, discovering, amplifying, and building exceptions allow clients to begin to view their situation differently and opens up possibilities for change. The model is more pleasant for the client and the therapist as cooperation is monitored and maintained throughout the course of therapy.

Evaluation of Skill Development as a Therapist

Evaluating one's own skill level is process which is filtered by perceptions, previous experience and training. There are a number of areas which clearly developed as a

result of this practicum and the internship program at the MacNeill Clinic. Perhaps the most notable change has been the increased clarity of thought, specifically in terms of assessment and the ability to clearly identify family structure. Prior to the internship this could be accomplished, however it was with a struggle, and tended to lack clarity. As a result of this practicum there is now an ability to clearly identify the family structures. In addition it is now possible to state what evidence supports the view.

The utilization of a specific model has consolidated past learning and experiences at a new level of understanding. There is a sense of having built a solid foundation. There is an awareness of the dimensions, and depth, in addition to the limitations that presently exist. This foundation has incorporated new structures and information, but was built using a combination of past learning and experiences as well. It is highly grounded in the structural model. In a sense it provides a primary view of families and interactions which highlights boundaries, subsystems, and hierarchies.

What has been added to this foundation is a solution focus. Although it fits quite well on top it has obscured the concept of pathology and the problem oriented focus. It has now become increasingly unclear what exactly the definition of

pathology. The solution focus addition includes a wide range of techniques and skills. Specifically it adds an enhanced ability to ask questions in manner that promotes change and encourages cooperation through understanding and validation. It also promotes attending to the language used by both one's self and the clients. The solution focus is by nature an open, expansive and evolutionary structure. It has the capability to be added to on a regular basis and is expected to continue to evolve over the years to come.

Conclusions

As a result of this practicum it has become clear that the structural model can be integrated with a solution focus. A poly-ocular perspective develops as a result of the interplay and relative influence the solution focus and the structural model have on each other. The bonus is a the higher logical type which manifests itself as an integrated model when both are utilized. This conclusion will attempt to elaborate and describe how one utilizes both these models and the influence each has on the other.

The structural model is often a clinician's first exposure to family therapy. Anyone who has sat with a family can describe the initial confusion as an attempt is made to sort the information and develop an understanding of what it

all means. The concepts of boundaries, subsystems, hierarchies, and roles, can be used as a means to sort information. The structural model provides a means to organize what one sees presented and to develop an understanding of how the family functions in a coherent manner.

The structural model is however firmly based on the identification of problems. According to Minuchin (1974) the problem or symptom is a result of an inappropriate family structure. This can be related to the family failing to accommodate to a particular stage of development. Or it can be in response to unresolved issues within the family. Therapy is directed at correcting this faulty structure. When this is accomplished the symptom can be expected to disappear.

Utilizing a solution focused approach calls into question the assumption that the problem (symptom) is a result of the family structure. It is equally possible that the structure of the family developed as a solution to the perceived problem. It suggests that the relationship between the structure and the symptom can be considered circular as opposed to linear. This punctuation of the relationship between the problem (symptom) and the structure can have an effect on the understanding of the problem.

When one believes that there is a complementary relationship, it can be seen how both the problem and the structure influence each other. In many ways it becomes an argument similar to the question of which comes first, the chicken or the egg? This initial assumption has profound influences on the understanding the therapists develops.

One of the assumptions of the solution focused approach is based on the constructivist idea that social reality is created (de Shazer & Berg, 1988, Hoffman, 1990, Weiner-Davis, 1990, May). Each of us filters information and develops perceptions based on our world view and this influences the manner in which we organize information. This personal "lens" notices information that fits with our perceptions and filters out information which does not. Examples of this can be seen in a parent's understanding and description of their adolescent's behavior. If the behavior is understood as lazy, then various behaviours and responses occur and are understood within this context. However, if the perception changes to sad, a different understanding and response develops. The solution focus thus informs the therapist about how the client understands the problem influences which solutions are considered.

The solution focused approach suggests that there are many ways of viewing a situation. And that one view is not

necessarily more correct than another. If one must choose a view it is helpful to choose one that leads to change (Weiner-Davis, 1990, May). It was found that an approach that focused on solutions, health, and ability promoted change. As a result it became increasingly difficult to maintain belief in the idea that inappropriate family structures lead to the development and maintenance of a problem. At the same time it is not useful or even reasonable to discard the structural model and all its concepts.

It is proposed that the structural model can maintain significant utility when a solution focus is incorporated. The idea that the structure is the cause or basis of the problem, however, has to be discarded. This does not mean that the family structure does not exert an influence on the problem. Rather, it is not the sole focus of the therapist's understanding of how and why the problem has been maintained. de Shazer (1988) suggests that calling a situation a problem is but one way of labelling and understanding an event. However, one must still have a basis for understanding how problems come into existence and are maintained.

Sluzki (1983) suggests that process, structure and world views all have an influence on the development and maintenance of problems. He concludes that,

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

de Shazer (1988) succinctly summarizes this idea by stating, "Problems can be seen to maintain themselves because of the context in which they occur in" (pp. 8). This concept allows the therapist to incorporate life cycle events, structures, interactional patterns, and family views. In addition it instructs the therapist to understand and interpret information provided by the family within the context they see themselves existing within.

The structural model provides the therapist with a means to organize information through the concepts of the model. Information requires a context within which it is understood. The structural model and its concepts provide a context which allows the therapist to observe the family's interactions and descriptions of the problem. The information can then be transferred or translated into structural terms. This method of understanding how a family functions is not present in the solution focused model which believes only the interactional

pattern that maintains the problem needs to be identified (de Shazer, 1988, de Shazer & Berg, 1988, Weiner-Davis, 1990, May).

This use of structural concepts is informed by current constructivist explanations regarding how therapy works. Solution focused and Eriksonian based approaches are presently exploring how language structures meaning and perceived realities (Anderson & Goolishian, 1988, Hoffman, 1990, de Shazer, 1988, Tomm, 1989, Weiner-Davis, 1990, May, White & Epston, 1990). One must therefore maintain an awareness that the concepts of the structural model and their use constitute an interpretation, through one's perceptions, of the meaning which can be ascribed to the family's pattern of relating. Personal history, values, and belief can be additional filters through which information passes. The solution focused approach cautions the therapist to only accept and place importance on what is directly seen and heard from the client(s). This approach restricts speculation regarding the cause of the problem, and thus reduces the risk of ascribing pathology to the family and/or members of it. Hypothesizing thus becomes limited to what is occurring, and how is it influencing each member of the system.

A solution focus depathologizes the structural model. In many ways this fits well with Minuchin's (1974) assertion that

no family is problem free, and the view that family patterns can be found along a continuum of behaviours. Minuchin and Fishman (1981) note that "the orientation of family therapist toward "constructing a reality" that highlights deficits is therefore being challenged. Family therapists are finding that an exploration of strengths is essential to challenge family dysfunction" (pp. 268). However, the structural model has remained present focused. In addition faulty family structure is seen as dysfunctional. The structural model can provide the therapist with a view of how the family functions prior to the resolution of the problem, and after it is solved. Rather than the structure being the focus of therapy, it provides the therapist with a means to understanding and evaluating the situation and the changes that are reported during the course of treatment. The family structure is not seen as the problem, rather it is a means to observe and track change. It provides the therapist with a an supplementary perspective from which to view and understand the changes a family may report during and upon completion of therapy.

Each model of therapy exerts an influence upon the other. One of the strongest influences of the structural model is that one cannot completely ignore the problem. What has become clear during this practicum is that families and individuals seeking therapy do want to talk about their problems. What seems to be of even greater importance is that

the solution to their problems fit within their worldview, and that, in general, families want to understand why the solution works.

de Shazer (1988) discusses how people often view their problems and the possible solutions within an either/or framework. He notes how this conceptualization is exclusive as it limits perceptions and solution development, while keeping people stuck in their problems. de Shazer (1988) proposes that many solutions can be found and fit within a both/and conceptualization which allows for the inclusion of a greater amount of information. The expansiveness of this orientation promotes the development of an expanded worldview and of subsequent solutions. de Shazer (1988), and Weiner-Davis (1990, May) both propose that one does not need to really know what the problem is. Identifying exceptions and what the solution will look like is sufficient.

Weiner-Davis (1990, May) also suggests that people entering therapy think of their problems in definitive terms. As a result the only future they can initially perceive includes the continuation of the problem. She suggests that an alternative view of the future can be developed through eliciting concrete behaviourial descriptions of what will be occurring when the problem is solved. This creates a new definitive future which includes a solution. It also

transforms the problem into a tentative definition which is open to new information and transformation.

In some circumstances this approach would seem to be sufficient. However in the case of families with adolescents, the presenting problem and the situations are often not clear cut. Families enter therapy with a belief, which may not be clear, regarding the source and cause of the problem. Frequently, it is seen as the result of a past emotional trauma such as a divorce, treatment by one parent, or perhaps both parents' perceived incompetence. In these cases, and others, the solutions need to either make sense and fit with the perception of the problem, or the therapist needs to expand and challenge the world view and accompanying perceptions, so that solutions outside the definition of the problem can be accepted.

It seems that focusing solely on solutions is simply the other side of focusing only on the problem. Although there are significant benefits to this approach it also seems to be a case of an either/or categorization. A both/and orientation fits with the use of both models, and offers an expanded range of alternatives and interventions. The both/and conceptualization allows the therapist to address and explore both problems and solutions, and to attempt to create a link between them. The solution focus generates cooperation,

questions, tasks, compliments, and a positive view of the family. This in turn fosters mutual respect, and encourages families to identify and accept their abilities, competencies, and strengths.

Therapy starts with the problem. Through exploration of its history and development one can determine each family member's worldview and how this is translated in the definition of the problem. The use of future oriented questions, while supporting and validating the individuals, allows the therapist to lead the family away from the problem towards a solution. When this occurs one can literally see family members becoming energized. There is a positive change in both affect and relationships between members as they move away from the despair, hopelessness, and blame of the problem towards the hope and relief of a solution.

One of the benefits of this approach is that families and individuals leave therapy with an understanding of how the problem occurred. More importantly they are clear about what steps they took towards resolving the problem, and what they would need to do should similar situation arise again. The combination of the two approaches promotes growth and understanding, while increasing a family's repertoire of problem solving strategies.

In conclusion, the approach advocated in this report utilized the concepts of both the structural model and a solution focus. Briefly summarized, the structural model was used to make an assessment of the family structure and how it was operating, rather than an assessment of the problem. The problem definition was based on the family's perception, statements, and behaviours. A solution focus was utilized to support each member, encourage cooperation, explore exceptions, and project the family into the future. The utilization of the structural model and a solution focus provides the therapist with a bonus of a higher logical type. Structural family therapy provides the therapist with a useful and efficient method for understanding how the family functions. It also provides a secondary method for recognizing, understanding, tracking and directing the changes a family may report during the therapeutic process. The solution focus orients the use of the model, the therapist, and the family away from the problem and towards a future in which the problem is resolved. Each model strongly influences the other in a synergistic manner. It is through this synergy that the bonus of a "higher logical type" results.

It is helpful to think of the terrain of therapy as a large uncharted map. Over the last century we have begun to explore and chart this vast terrain through the development of models of therapy. Each of the models discussed in this

report is but a section of the terrain, and by no means should they be understood as "the map". The solution focus and the structural model do overlap, and both can provide some direction over the same area. In the same way a road map and a topological map can be of the same location but provide different information, and thus a different perspective of the same place.

The two therapeutic models of this report, as well as the individual and the family life cycle paradigms are but some of the constructs used by therapists in order to understand where their clients are, and hopefully provide some ideas regarding a reasonable direction for the work to go. The use of one model to the exclusion of other can be considered similar to viewing a scene through a limited lens. Lenses can filter out portions of the visible spectrum, depth of field, or the surrounding scenery which provides the context for what one sees. Taken to the extreme, a limited lens can view a portion of a map, and see a small lake. Through this limited lens the surface is all water. All because the lens was not open to sufficient information.

Opening up the lens to additional models and points of view offers a more expansive and informed view of the therapeutic process. It is expected that the structural model and the solution focus will continue to be modified and

further developed, as will other models. It is hoped that eventually we will understand the therapeutic process well enough to begin to put together all the various sections of knowledge and begin to develop an understanding of what the whole map looks like. Hopefully we will have the ability to keep our lenses open so that we may fully understand the complexities, diversities and abilities that our clients bring with them when they enter therapy.

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Appendices

Appendix A - Family Assessment Measure (FAM III) ; Authorization, the General Scale, & Interpretation Guide

April 2, 1991.

Addiction Research Foundation

Fondation de la recherche sur la toxicomanie

Central Office
Siège social

33 Russell St
Toronto Ontario
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33 rue Russell
Toronto Ontario
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Tel (416) 595 6000
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Bill Brodovsky

Dear Mr. Brodovsky,

I am responding to your letter regarding the Family Assessment Measure. You have my permission to use FAM-III in your practicum research with adolescents and their families - evaluation of outcome therapy.

Please respect the copyright and do not make the FAM available to others or reproduce it without written permission.

Obviously, I would be quite interested in your findings. All the best with your research and please let me know if I can provide you with further information.

Sincerely,

Dr. Harvey A. Skinner
Professor and Chairman
Department of Behavioural Science
Faculty of Medicine
University of Toronto
and
Senior Scientist
Addiction Research Foundation

GENERAL SCALE

Directions

On the following pages you will find 50 statements about your family as a whole. Please read each statement carefully and decide how well the statement describes your family. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE with the statement then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

Please do not write on this page.
Circle your response on the answer sheet.

1. We spend too much time arguing about what our problems are.
2. Family duties are fairly shared.
3. When I ask someone to explain what they mean, I get a straight answer.
4. When someone in our family is upset, we don't know if they are angry, sad, scared or what.
5. We are as well adjusted as any family could possibly be.
6. You don't get a chance to be an individual in our family.
7. When I ask why we have certain rules, I don't get a good answer.
8. We have the same views on what is right and wrong.
9. I don't see how any family could get along better than ours.
10. Some days we are more easily annoyed than on others.
11. When problems come up, we try different ways of solving them.
12. My family expects me to do more than my share.
13. We argue about who said what in our family.
14. We tell each other about things that bother us.
15. My family could be happier than it is.
16. We feel loved in our family.
17. When you do something wrong in our family, you don't know what to expect.
18. It's hard to tell what the rules are in our family.
19. I don't think any family could possibly be happier than mine.
20. Sometimes we are unfair to each other.
21. We never let things pile up until they are more than we can handle.
22. We agree about who should do what in our family.
23. I never know what's going on in our family.
24. I can let my family know what is bothering me.
25. We never get angry in our family.

Please do not write on this page.
Circle your response on the answer sheet.

26. My family tries to run my life.
27. If we do something wrong, we don't get a chance to explain.
28. We argue about how much freedom we should have to make our own decisions.
29. My family and I understand each other completely.
30. We sometimes hurt each others feelings.
31. When things aren't going well it takes too long to work them out.
32. We can't rely on family members to do their part.
33. We take the time to listen to each other.
34. When someone is upset, we don't find out until much later.
35. Sometimes we avoid each other.
36. We feel close to each other.
37. Punishments are fair in our family.
38. The rules in our family don't make sense.
39. Some things about my family don't entirely please me.
40. We never get upset with each other.
41. We deal with our problems even when they're serious.
42. One family member always tries to be the centre of attention.
43. My family lets me have my say, even if they disagree.
44. When our family gets upset, we take too long to get over it.
45. We always admit our mistakes without trying to hide anything.
46. We don't really trust each other.
47. We hardly ever do what is expected of us without being told.
48. We are free to say what we think in our family.
49. My family is not a perfect success.
50. We have never let down another family member in any way.

FAM Interpretation Guide

1. TASK ACCOMPLISHMENT

LOW SCORES (40 and below) STRENGTH
- basic tasks consistently met
- flexibility and adaptability to change in developmental tasks
- functional patterns of task accomplishment are maintained even under stress
- task identification shared by family members, alternative solutions are explored and attempted

HIGH SCORES (60 and above) WEAKNESS
- failure of some basic tasks
- inability to respond appropriately to changes in the family life cycle
- problems in task identification, generation of potential solutions, and implementation of change
- minor stresses may precipitate a crisis

2. ROLE PERFORMANCE

LOW SCORES (40 and below) STRENGTH
- roles are well integrated: family members understand what is expected, agree to do their share and get things done
- members adapt to new roles required in the development of the family
- no idiosyncratic roles

HIGH SCORES (60 and above) WEAKNESS
- insufficient role integration, lack of agreement regarding role definitions
- inability to adapt to new roles required in evolution of the family life cycle
- idiosyncratic roles

3. COMMUNICATION

LOW SCORES (40 and below) STRENGTH
- communications are characterized by sufficiency of information
- messages are direct and clear
- receiver is available and open to messages sent
- mutual understanding exists among family members

HIGH SCORES (60 and above) WEAKNESS
- communications are insufficient, displaced or masked
- lack of mutual understanding among family members
- inability to seek clarification in case of confusion

4. AFFECTIVE EXPRESSION

LOW SCORES (40 and below) STRENGTH
- affective communication characterized by expression of a full range of affect, when appropriate and with correct intensity

HIGH SCORES (60 and above) WEAKNESS
- inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotions appropriate to a situation

5. AFFECTIVE INVOLVEMENT

LOW SCORES (40 and below) STRENGTH
- emphatic involvement
- family members' concern for each other leads to fulfillment of emotional needs (security) and promotes autonomous functioning
- quality of involvement is nurturant and supportive

HIGH SCORES (60 and above) WEAKNESS
- absence of involvement among family members, or merely interest devoid of feelings
- involvement may be narcissistic, or to an extreme degree, symbiotic
- family members may exhibit insecurity and lack of autonomy

6. CONTROL

LOW SCORES (40 and below) STRENGTH
- patterns of influence permit family life to proceed in a consistent and generally acceptable manner
- able to shift habitual patterns of functioning in order to adapt to changing demands
- control style is predictable yet flexible enough to allow for some spontaneity
- control attempts are constructive, educational and nurturant

HIGH SCORES (60 and above) WEAKNESS
- patterns of influence do not allow family to master the routines of ongoing family life
- failure to perceive and adjust to changing life demands
- may be extremely predictable (no spontaneity) or chaotic
- control attempts are destructive or shaming
- style of control may be too rigid or laissez-faire
- characterized by overt or covert power struggles

7. VALUES AND NORMS

LOW SCORES (40 and below) STRENGTH
- consonance between various components of the family's value system
- family's values are consistent with their subgroup and the larger culture to which the family belongs
- explicit and implicit rules are consistent
- family members function comfortably within the existing latitude

HIGH SCORES (60 and above) WEAKNESS
- components of the family's value system are dissonent resulting in confusion and tension
- conflict between the family's values and those of the culture as a whole
- explicitly stated rules are subverted by implicit rules
- degree of latitude is inappropriate

(Skinner, Steinhauer, & Santa-Barbara, 1983, pp. 101)

Appendix B - Problem Checklist

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

Name: Date:	very dis-satis-fied	dis-satis-fied	in be-tween	satis-fied	very-satis-fied
1. showing good feelings like happiness, joy pleasure etc.					
2. sharing feelings like anger, sadness, hurt					
3. sharing problems with the family					
4. how rules are made					
5. the rules of the family					
6. how household chores are shared					
7. how anger and frustration are handled					
8. dealing with matters concerning sex					
9. use of drugs and alcohol					
10. use of discipline					
11. use of physical force					
12. the amount of independence you have					
13. amount of contact with friends					
14. amount of contact with relatives					
15. relationship between parents					
16. relationship between children					
17. relationship between parents and children					
18. amount of time together as a family					
19. situation at work or school					
20. family finances					
21. housing situation					
22. overall satisfaction with my family					
23. make this last rating for yourself: feeling good about myself					

Appendix C - Client Feedback

1. Did you feel that I understood your family and the problem that you were experiencing ?

2. Did you feel that I was really interested in helping you and your family solve the problem ?

3. Was there anything in particular that I said, did, or suggested that you found most helpful ?

4. Was there anything in particular that I said, did, or suggested that you found not helpful at all ?

5. In general how satisfied are you and your family with the service you received?

6. Is there any kind of service or help you or your family expected or needed that you didn't receive ?

7. Did you and your family accomplish what you set out for yourselves ?

Appendix D - Overall Score Pre/Post Test Results Using the FAM III General Scale

Family	Subject	Pre test	Post test
A	Mother	71	55
C	Father	53	58
	Mother	56	52
	Son	66	57
D	Uncle	44	51
	Aunt	63	553
	Neice	48	42
E	Foster Mother	48	54
	Foster Son	69	44
F	Father	47	48
	Mother	43	33
G	Mother	45	46
	Daughter	51	51
I	Daughter	62	59

Overall Score Pre/Post Test Results Using the FAM III General Scale (con't)

Family	Subject	Pre test	Post test
J	Mother	67	67
	Daughter	69	59
K	Mother	64	61
	Daughter	76	69
L	Mother	65	63
	Daughter	68	68
	Daughter	57	62
M	Father	63	52
	Mother	67	52
	Son	57	54
N	Stepfather	58	51
	Mother	62	53
	Son	69	50
O	Mother	60	48
	Son	54	45
	Daughter	55	55