THE CRISIS OF A CANCER DIAGNOSIS IN THE FAMILY: A SOLUTION FOCUSED BRIEF THERAPY APPROACH

BY

HEATHER NEILSON-CLAYTON

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University of Manitoba
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A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

Abstract

This practicum describes the effects that a diagnosis of cancer has on the family system when an adult has been diagnosed with this disease. The implications that this disease will have for the spouse and on his or her role within the family system are explored. This report examines the use of the Brief Family Therapy Centre's solution focused brief therapy as a model of practice with these families. Concepts of the solution focused brief family therapy model are discussed.

The model of practice is evaluated with the FAM III General Scale, a therapeutic scaling question in the form of a client self-anchored scale and a therapist rating scale, and client feedback. Two case examples are provided to illustrate the use of this model, and results of the evaluation are discussed.

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INTRODUCTION AND OBJECTIVES

Educational Goals and Objectives of the Practicum

Goal: #1

To apply the solution focused brief therapy model to spouses of cancer patients within the context of the family system.

Outcome Objectives

1. Demonstrate a conceptual understanding of and practice skills in the solution focused brief therapy model. The means to achieve this objective are twofold:

    a. undertake a literature search on the use of solution focused brief therapy, with particular emphasis its application to spouses of cancer patients in the context of the family system.

    b. apply solution focused brief therapy concepts

and skills in working with spouses of cancer patients in the context of the family system.

2. Demonstrate a working knowledge of the solution focused brief therapy model with particular emphasis on families dealing with physical illness and loss.

3. Demonstrate an ability to conceptualize and apply the use of the solution focused brief therapy model with families of adult cancer patients when the spouse has been identified as having the problem or complaint. This can only be achieved if appropriate referrals are available.

4. Demonstrate an ability to apply the techniques of the solution focused brief therapy model in therapeutic situations. This will be achieved by the following:

   a. identifying the type of client-therapist relationship.

b. developing rapport or fit with the client system and taking responsibility to promote fit throughout treatment.

c. redefining the client problem/complaint by searching for exceptions to the problem/complaint, and using positive focusing toward realistic solutions to provide encouragement for early resolution.

d. negotiating goals with the client and using techniques of task setting to help the client accomplish these goals.

e. helping clients to reach a level of functioning that they feel is satisfactory.

5. Demonstrate the ability to differentially apply the model to spouses of adult cancer patients within a systemic and ecological framework. This will be achieved by assessing the spouse's behaviour at pre-intervention and post-intervention phases.

Goal: #2

Using the solution-focused brief therapy model, improve family functioning in families of adult cancer patients when the spouse has been identified as having the problem/complaint.

Outcome Objectives:

1. Upon completion of the solution-focused brief therapy intervention, the family system will be coping at a functional level.

2. Upon completion of the solution-focused brief therapy intervention, the client system's problem/complaint will be minimal or absent.

Introduction

In Canada, 116,200 new cases of cancer were diagnosed in 1993, an increase of 1,200 newly diagnosed cases compared to the previous year (National Cancer Institute of Canada, 1993). As cancer continues to impact upon a significant proportion of the population, it inevitably influences the many family members in their attempts to cope. When assessing the psychosocial needs of an individual who has been diagnosed with cancer, it is essential that the entire family system is also considered.

When a family is referred for assistance, often a crisis has occurred because of a diagnosis or recurrence of cancer. For some, the crisis may subside as family members regain some level of stability in their lives. Others may find they do not have the emotional resources to cope with the devastating effects of a cancer diagnosis. There are feelings of anger, denial, hopelessness and despair. Seeking therapy may seem like an unnatural step for them to take.

For a therapist to intervene effectively he or she must understand the crisis caused by this disease, and the role and relationship changes that inevitably occur. Using a systemic perspective allows the therapist to incorporate a view that includes the individual in the context of the family, existing in society. This conceptual focus provides a better understanding of the problem at hand.

According to de Shazer (1991), solution focused brief therapy is an effective model of practice in clinical situations. However, no evidence exists evaluating its effectiveness with families living with cancer. Solution focused brief therapy has been chosen as a model for practise because of the utility of its therapeutic techniques, its theoretical applicability to the idea of cancer as a crisis, and because the literature lacks any evidence of a pure application of the model to this population.

The literature review of this report will be divided into two sections. The first section, chapter one, will review the literature concerning crisis theory in the

context of families living with cancer. The second section, chapter two, will review the literature concerning the use of brief therapy and the conceptual assumptions of the solution focused family therapy approaches as an intervention model.

CHAPTER ONE

THE CRISIS OF CANCER

Introduction

This chapter discusses crisis theory in the context of the family affected by a diagnosis of cancer. The nature of role changes within the family system because of crisis is examined. Potential problems such as overburden, inadequate skills, inappropriate roles, and social role implications are reviewed. Stressors peculiar to the cancer experience that potentiate crisis are also discussed as is the nature of communication in facilitating crisis resolution.

Cancer as a Crisis

According to Caplan (1964) individuals strive to maintain a state of psychological equilibrium or emotional homeostasis, which maximizes daily functioning. This equilibrium is sustained by problem-solving mechanisms and reactions which are employed in daily life when threatening events disturb the balance. These problem solving mechanisms and reactions are habitual in that they exist in the individual's repertoire of coping mechanisms by virtue of previous learning. When a

situation emerges that does not respond to the usual coping mechanisms, a state of crisis results. Caplan defines an emotional crisis as an increasingly intolerable mood state marked by a period of disorganization during which many attempts at solution are made until some kind of adaptation is achieved. The adaptation, however, may not necessarily be in the best interest of the individual or those around him.

Embracing the systemic view, it is recognized that the individual is embedded within an interpersonal context, a recipient and practitioner of redundant patterns of interaction which influence and counterinfluence behaviour. In his relations with others in his social system, he plays complementary roles related to his position in the structure of his society. The normal consistency of pattern, or equilibrium, is maintained by homeostatic re-equilibrating mechanisms, so that temporary deviations from the pattern call into operation opposing forces or behaviours designed to bring the pattern back to its previous state. Within a system, for example, grouping and regrouping according to the requirements of the stressor is often employed as a

coping mechanism. However, as on the simpler level, if the coping mechanism does not exist in the repertoire of previously learned behaviour, a crisis ensues and disorganization follows until adaptation is finally reached. The adaptation, again as in the simpler case, may not necessarily be appropriate and may indeed set the stage for additional stress.

In the context of the family, this implies that when faced with a potentially homeostatically upsetting situation, the family will continue to function since established roles continue to be fulfilled and members continue to interact in accordance with that family's rules for the system. This however necessitates flexibility by family members so that roles can become interchangeable while simultaneously, a well-defined boundary still exists between family members. In the case, for example, where the father of an adolescent daughter contracts a life threatening disease, some role reversal may take place such that the daughter may assume some parenting responsibilities in the form of caregiving. However, the boundary between parent and child needs to continue to exist. The family which

experiences dysfunction in the face of a potentially threatening event, although it may experience periods of adaptation, displays inability on an individual and a family level to continue with life's tasks due to inflexibility or inability to interchange roles.

Crisis occur naturally throughout the family life cycle, and most individuals and their families cope effectively, generating new and useful skills in which to negotiate their world. Prior to the diagnosis of a major disease, the family may never have had to negotiate a situation which is perceived as threatening the life of a member, and the integrity of the system as a whole. When a critical illness strikes, this problem may be beyond what the individual and family systems are able to cope with and they may become at risk for developing dysfunctional patterns of adaptation (Cassileth, 1979; Freedman, 1982; Zahlis & Shands, 1991). A cancer diagnosis, for example, is representative of what Caplan (1964) describes as a "larger problem stimulus". The family may never have dealt with a problem of this magnitude, and in their efforts to cope, may experience what he describes as "unsuccessful re-equilibrium forces"

that lead to a state of crisis.

As cancer and treatment progresses, the patient learns to assume a "sick role" in the family system (Bloom & Spiegel, 1984; Cassileth, 1979; Zahlis & Shands, 1991). This sick role, which develops in the context of medical and health issues, is unfamiliar and as a result, the individual and family system may feel somewhat disoriented as this new role evolves. It may become necessary that the individual with cancer learns to accept a restricted lifestyle. At the same time that this new and often unfamiliar role is being assumed, efforts to adapt to a cancer diagnosis and maintain a sense of homeostasis in the family system mean that responsibilities once held by the individual with cancer must be transferred to other members (Cassileth, 1979; Cooper, 1984; Goldberg, Wool, Glicksman & Tull, 1985; Zahlis, Shands, 1991). According to Vess Jr., Moreland and Schwebel (1985a, 1985b) when cancer strikes, the family system adapts by reallocating roles to accommodate for the member who is unable to maintain role responsibilities as a result of illness. When the family member with cancer is an adult, role and lifestyle

changes within and outside the home may be extreme. The ability of cancer to influence roles, such as those of being a parent, spouse or a "breadwinner" may leave families emotionally, socially and financially exhausted. Thus the emotional distress associated with being a spousal caregiver stems not only from concern for the spouse's health but also from the need to adjust to the changing nature of their relationship with the patient as joint responsibilities and roles are redefined.

Three factors are believed to influence families successful reallocation of roles (Vess Jr. et al. 1985a, 1985b). First spouses' communication patterns strongly influence how well reallocated roles are enacted, the amount of role strain and role conflict, and the level of cohesion and conflict in the family. Second, open communication positively influences the family environment resulting in less role strain and less role conflict. Third, the method that the family uses for reassigning roles also significantly influences how well roles are performed and the level of cohesion in the family. Families that use "achieved" roles - acquired by an individual's own effort and abilities, rather than

using "ascribed" roles - assigned by uncontrolled characteristics such as age or gender, are less likely to experience role-overload problem and are more likely to engage in external redistribution. Since adaptation to stress is largely dependent on previously learned and otherwise successful patterns of response, the typical pattern of the family structure is crucial in determining response to crisis situations. If previous family rules about gender or age roles were rigid, families are unlikely to possess the flexibility required to adequately redistribute roles. Similarly, just as role redistribution is a primary mechanism for facilitating homeostasis, so is communication the primary facilitator of adequate role assumption and allocation.

When the person with cancer is an adult, a spouse is commonly the person who assumes many of the responsibilities once held by the individual with the disease (Zahlis & Shands, 1991). These additional responsibilities can have a significant impact on both the marital dyad and upon the spouse caregiver's well being, particularly when role redistribution has proceeded such that the spouse is overburdened with

responsibilities. For example, most familial caregivers are either wives, mothers, or daughters of the patient and there is some indication that the caregiving experience is more stressful to women because of rigid gender-based rules about the type of caregiving tasks expected and because caregiving males are less likely to be assigned the role of sole caregiver (Siegel, Raveis, Mor & Houts, 1991). Exhaustion and deteriorating physical health are problems which overburdened spouses may face as a result of caregiving burdens (Jensen & Given, 1991; Zahlis & Shands, 1991) and are difficulties which are magnified by the nature of the fact that cancer patients and their spouses are predominantly in their senior years upon diagnosis (National Cancer Institute of Canada, 1993). Similar problems are apparent when through "ascribed roles" the person assigned a particular role does not have the skills or abilities required to effectively carry out the tasks involved. This may be the case for example when young children or adolescents are expected to become the sole emotional support for the patient or caregiving parent.

Just as the individual is part of the larger family

system, so is the family dependent in part on a larger social system for support in order to accomplish its daily life tasks, alleviate burden, provide emotional support, and provide information about new, successful coping strategies. In addition, there is a massive body of research indicating the crucial importance of social support for the well being, psychological adjustment and perhaps even prognosis of cancer patients. However, the lifestyle adjustments which occur as a result of developing cancer may significantly alter the cancer patient's level of social functioning. According to Bloom and Spiegel (1984), social exchange erodes during life threatening illness such as cancer as a result of the limitations imposed by the illness on one's opportunity for social interaction. The individual may have less energy to expend as a result of the illness. This energy is put toward accomplishing necessary tasks which means that little remains for social interaction, such as visiting with friends. When energy is limited to the point that the cancer patient is unable to maintain adequate social contacts, the psychological distress associated with the disease can be expected to intensify.

To some degree, the increased need for social support coupled with the limitations placed on social interaction by the disease require family members to take on an additional role. Often the spouse attempts to fulfil or is assigned the role and becomes responsible for gratifying much more of the patient's social and emotional needs than previously required. Although this may satisfy the patient's social needs, it may further overburden the caregiver, particularly since their increased responsibilities and already age-related limits on social exchange may leave little time or energy for social interaction away from home. Indeed the research available suggests that a majority of cancer patients perceive the quality of emotional social support they receive as outstanding (Dunkel-Schetter, 1984; Lichtman & Taylor, 1986). On the other hand, Stommel and Kingry (1991) have found that there is likely to be a lack of adequate support for spouse caregivers, and Goldberg and colleagues (1985) have found that spouses of cancer patients are susceptible to psychological problems, specifically depression, if their own interest and involvement in the social environment is limited. In studies specific to head and neck cancers, in which

patients tend to have a good survival rate but typically poor psychosocial adjustment, researchers have noted higher levels of depression, tension, and fatigue in spouses than in patients (Mathieson, Stam & Scott, 1991). This is of particular significance when one considers that the psychosocial problem of head and neck cancer patients tend to be extremely long term and marked in the level of deterioration over time (Rapoport, Kreitler, Chaitchik, Algor & Weissler, 1993).

The value of communication as a powerful facilitator in the successful adaptation of the family cannot be overscored. Role reorganization will not be adaptive if parties cannot effectively communicate the responsibilities required to fulfil unfamiliar tasks, or if they cannot or will not admit overburden, or ask for assistance from within or outside the family. Sabo, Brown and Smith (1986), for example, found that male caregivers who took on a protective or minimizing role and hid their emotional involvement when dealing with their wives who had undergone a mastectomy, only served to increase their own and their partners levels of distress. Similarly, information about the patient's

experience of the illness is crucial in determining a caregivers sense of helping (Chaitchik, Kreitler, Rapoport & Algor, 1992). Family members who experience a sense of helplessness due to lack of information about the disease or as a result of a lack of skill or overburden can be expected to experience unnecessary psychological distress (Vachon, Freedman, Forms, Rogers, Lyall & Freedman, 1977) A plethora of evidence also summarized by Chaitchik and colleagues (1992) exists indicating that effective communication increases patient compliance to treatment, modifies the patient's perception of stressful events, eases the burden of decision making in regard to treatment, and enhances external social support. The research of Clipp and George (1992) and others (Chaitchik et al., 1992; Mathieson, Storm & Scott, 1991) points to the difficulty that families may have in maintaining open communication about the illness experience and the risk of the marital relationship deteriorating when an adult is diagnosed with cancer.

To a large extent, the particular stresses and crisis experienced by families facing a cancer experience

are not unique to the disease. However, it is also generally recognized that a diagnosis of cancer often carries a greater threat than that of other life threatening and potentially disfiguring, debilitating and recurrent diseases because of the connotations of the illness (Krause, 1991). Cancer is considered by society as a synonym for death, a perception which has been maintained by society since the early days in spite of increasing odds for survival (Cooper, 1984) and a persistent "Cancer can be beaten" campaign. According to Seffrin, Wilson and Black (1991) in their review of perceptions about cancer and the cancer care system, one of every three people regard a diagnosis of cancer to be a death sentence. Similarly, medical students and physicians harbour more negative feelings about cancer patients than patients in general and workplace discrimination aimed at cancer patients is well documented (Seffrin et al., 1991). This cultural perception of the "Big C", so feared that we find euphemisms to avoid speaking the word, and the "Cancer can be beaten" response to it have resulted in the development of a distinct stigma which is attached to cancer. Not only is the patient often viewed with pity

as a person whose days, sure to be marked by excruciating pain and disfigurement, are numbered but there may also be a sense that to "lose" the fight against cancer implies personal weakness, or that they lack the willpower to beat it, or that patients get cancer because they want or need to (Cassileth, 1989). Indeed, coupled with the popular holistic health model, the cancer can be beaten message allows those without cancer and perhaps the patient as well to believe that people who get cancer bring it on themselves. As Northhouse and Wortman (1990) have expressed it, we do not want to believe that in a just world bad things can happen to good people without reason.

The result is a number of additional stressors which serve to fuel the crisis in a number of interrelating ways and which may also prevent resolution and adaptation (Cassileth, 1979; Cohen, 1982; Cooper, 1984; Mailick, 1979). First, for the individual who develops cancer, this stigma has an influence on his self-image (Cassileth, 1979; Cohen, 1982; Mailick, 1979). According to Cassileth (1979), self-image changes after diagnosis as the individual begins to perceive himself as a "cancer

victim". This perception is maintained by the individual even after treatment is completed as he continues to think of himself as a "cancer patient". Furthermore, when one of its members is diagnosed with cancer, the family's perceptions, which are also coloured by the values of society, influence how they are likely to respond within the context of the disease (Cohen, 1982). For example, even when the individual's prognosis is good, the stigma of cancer may influence the family to respond with pessimism. In a sample of 30 couples, Clipp and George (1992), for example, found that almost without exception, spouses reported a more pessimistic view of the illness than their partners with cancer. Baider and Sarell (1984) and Cooper (1984) made similar findings. Family's reactions to a cancer diagnosis are critical because of how they may influence the image that the individual has of himself. Negative feedback from family members serve to reinforce the individual's conceptual view as he learns to think of himself as a cancer patient, a victim to this disease, or a failed hero.

CHAPTER TWO

CLINICAL MODEL OF INTERVENTION

Introduction

This chapter presents evidence that solution focused brief family therapy is an appropriate and effective means of treating the psychosocial problems associated with cancer. The review demonstrates that a natural corollary exists between crisis theory and solution oriented brief family intervention. The success of a number of intervention studies are examined in light of commonalities such as an emphasis on learning and a focus on periods of homeostasis as providing solutions for times of crisis. The chapter also describes the model's basic theoretical concepts, main principles of practice, and techniques for therapeutic intervention.

Solution Focused Brief Therapy

Understanding cancer as an illness that has a significant impact on the family system reinforces the notion of using family focused social work practise to support families through the difficulties that this type of illness brings. The family therapist can join the family system to assist with the many changes and

transitions that the family will experience following a diagnosis of cancer, through the coarse of this disease, and in the event of the patient's death. Family systems theory enables a view of the patient not as an isolated individual, but as an interacting and reacting member of a mutually-dependent unit (Guttman, 1991). Knowledge of the family's needs and interpersonal dependencies is critical when assisting the family in crisis to regain homeostasis and in determining the need for intervention. The field of family therapy is characterized by a large body of theories about the nature and relative effectiveness of different techniques and by a number of research studies testing these clinical theories. A considerable amount of research devoted to assessing the outcomes of family therapy intervention has lead authors who have reviewed this material to a convincing conclusion that the practice of family therapy leads to positive outcomes (Gurman & Kniskern, 1978; Gurman, Kniskern & Pinsof 1986; Wells & Dezen, 1978). One can be reasonably confident then, given the enormous amount of theoretical and research literature available, that family focused interventions are valid ways to work with families to improve psychosocial adjustment.

In the field of cancer care, limited research is available which evaluates the effectiveness of using family focused therapy as a mechanism for intervention with families affected by the onset of a cancer diagnosis. In fact, Pederson and Valanis (1988) and Christensen (1983) have commented upon the general lack of intervention studies in the area of cancer care, noting that the greatest percentage of the enormous amount of literature in this area is either descriptive or assessment oriented. However, there are some general family focused intervention studies which have produced improved psychosocial adjustment of the cancer patient and family members (Christensen, 1983; Heinrich & Schag, 1985; Roberts, Elkins, Baile, Jr., & Cox, 1989). Roberts and colleagues (1989) found that family focused intervention decreased depression and reduced levels of anxiety for the cancer patient. Heinrich & Schag (1985) also found a significant impact following a family focused intervention. Family members of cancer patients demonstrated changes in their abilities to cope with the illness, including increased levels of interaction within their own social network of family and friends. Finally, Christensen (1983) evaluated the effects of a structured

couples treatment program and concluded that intervention with couples following a mastectomy reduced emotional discomfort in cancer patients and their partners, reduced depression in the patient, and increased sexual satisfaction for both spouses.

A plethora of theoretical literature describing the effects of cancer on the family system and supporting these research findings is available. For example, Pederson and Valanis (1988), in a review of the literature, noted that family focused intervention strategies that addressed education and communication needs, role and relationship changes and difficulties in interacting with the health care system were seemingly effective in reducing levels of stress experienced by families living with cancer. Similarly, Keitel, Cramer and Zevon (1990), in a review of the literature, noted the importance of using family focused interventions which provide a forum for information, address family issues associated with the disease, and provide an opportunity for family members to receive emotional support. Others have noted the effects of providing information and education to cancer patients and their

families, reporting increased coping skills (Arnowitz, Brunswick & Kaplan, 1983; Herzoff, 1979; Schaefer, 1985; Wellisch, 1985) and increased feelings of control (Schaefer, 1985; Wellisch, 1985). This material adds strength to the findings of the research literature presently available and, when considered in light of the view of cancer as a family disease as discussed previously in this report, encourages the practise of family therapy in cancer care.

Included in the well-entrenched field of family therapy are models of practise which use a brief therapy approach. There is much confusion about what "brief therapy" really means and it is commonly distinguished by the number of sessions used to complete the therapeutic process. In the case where the number of sessions is the defining factor, therapy will be considered "brief" if it fits within the decided number of sessions. However, according to Cummings (1986), "Brief therapy does not mean less therapy; it means more efficient therapy (p.429)." More efficient therapy is made possible by an application of the following tenets. 1. Sessions are therapeutic right from the first visit. While some

history is necessary, it need not be the focus of an entire session. 2. An operational diagnosis should be performed. Cummings (1986) suggest that the operational diagnosis is made apparent by asking why the patient is seeking therapy at this moment as opposed to yesterday or a month from now. 3. A therapeutic contract should be created and discussed with attainable goals clarified. 4. Homework should be used whenever possible. 5. Intervention should be targeted to the goal.

De Shazer (1985) believes that to understand the meaning and importance of brief therapy, it is necessary to conceptualize brief therapy from the perspective of solving human problems. For example, when a family experiences a crisis, the period of disequilibrium experienced by the family is extremely stressful, therefore therapy must be geared to resolving the problem as quickly as possible for the benefit of the client system. Given this perspective, resolution of the client problem becomes the factor that structures the therapeutic intervention, rather that allowing a predetermined number of sessions to dictate the intervention process. The length of time clients remain

in therapy also is of relevance and must be considered. According to de Shazer (1985) and Fisher (1984), most individuals, couples and families remain in treatment on the average of six to ten sessions, this means that there is a limited amount of time for problem resolution to occur. When working with families then, the goal for the therapist is to approach each therapeutic session, attempting to address therapeutic needs of the client system in as limited a time as possible. Therapists are ethically compelled to provide the best service possible in the limited time available and so must be realistic in planning intervention. Using the brief therapy model, the therapist makes an assumption that each session could be the last session with the client, therefore ensuring that in each session there is an opportunity for clients to reach a resolution for the identified problem that brought them to therapy and to the end of the therapeutic relationship.

An additional consideration is that brief therapy is an effective way of reducing financial strain on the health care system (Budman & Stone, 1983; Cummings, 1985, 1986). This is a consideration of particular importance

in cancer care as the incidence of cancer increases proportional to the aging population (Cummings, 1985). In times of financial constraint, clients who are in efficient short-term intermittent therapy save money, and support the likelihood that such a service will continue to remain available. In fact, one of the earliest proponents of the brief therapy model has made a convincing argument that the salvation of mental health services in general lies in a move towards brief, intermittent, goal targeted intervention (Cummings, 1986). Cummings and his colleague, Follette, present evidence that even one session with no repeat psychological visit can reduce medical use by sixty percent and by seventy-five percent in patients receiving two to eight brief therapy sessions (Cummings & Follette, 1968). Similarly, results indicating resolution for eighty percent of clients in only five sessions have demonstrated the efficacy of solution focused brief family therapy (de Shazer, 1991). In a review of emerging trends in group psychotherapy, Spitz (1984) also identified short term, focused and goal oriented family therapy groups as being the most successful type of multi-family intervention. A therapy which is

instrumental in assisting families affected by cancer to overcome intermittent crisis within only a few sessions is economical for the health care system and will ensure that this type of approach remains a viable resource now and in the future.

The effects of brief family counselling during periods of crisis on promoting the general well being of the family has been successfully demonstrated by Bunn and Clarke (1979) who compared the anxiety levels of counselled and non-counselled relatives who accompany seriously ill or injured patients to the hospital. Bunn and Clarke believe that the repercussions of such brief interventions are far reaching since the adjustment of the family is a contributing factor to the patient's speed of recovery and to the patient's mental health. Furthermore, since high levels of anxiety are known to be debilitating, and the family is the primary means of social support and care for the patient, any reduction in heightened anxiety will have an overall beneficial effect in caregiving.

In reviewing the literature on brief therapy it

becomes increasingly obvious that interventions emphasizing some type of educational or informational skills component such as communication are particularly effective. The effectiveness of didactic intervention is not surprising in view of an important corollary to crisis theory; that there is an enhanced ability and capacity for learning during the state of emotional crisis (Baldwin, 1979). And not only do clients appear to learn more efficiently during the crisis state, such learning appears to be long lasting. Heinrich and Schag (1985), for example, found that families participating in coping and communication intervention during the crisis of cancer diagnosis continued to apply these skills to resolve other non-cancer related crisis and conflicts. Similarly, brief family interventions which incorporate communication skills and information are particularly effective due to the nature of the family as an interrelated, interdependent system. As cited earlier, Vess Jr. et al. (1985a, 1985b) has emphasized the role of communication in the successful allocation of roles and on the amount of role strain within the family. The social stigma of diagnosis, survivorship, or palliation resulting from the disease must also be attributed, to

some extent, to lack of knowledge and communication about cancer. And finally, the tendency of the disease process to impinge on the social interactions of the patient and family caregiver can be expected to respond to changes in communication patterns. Thus, for example, in a review of the literature on changing trends in psychotherapy, Spitz (1984) cites evidence demonstrating that, like interventions designed for individuals, the most effective brief therapy interventions for marital complaints generally included some form of communication enhancement. Heinrich and Schag (1985), Christensen (1983), Pederson and Valenis (1988), and Rainey (1985) all report successful cancer patient family intervention using communication, education and information in brief therapies.

The success of family interventions which incorporate some form of skill development, learning, and information accounts, to some degree, for the proliferation of the support group movement in cancer care. In general, it is widely acknowledged that the role of support and self help groups in helping families cope with cancer lies in providing an educational forum

designed for the acquisition of coping strategies (Busick, 1989; Herzoff, 1979; Lieberman, 1988). In an evaluation of a family and friends support group, Plant and colleagues argue that information is the most effective form of intervention in cancer care and suggest that groups provide a forum whereby families can learn new coping strategies from others without investing in a protracted trial and error period (Plant, Richardson, Stubbs, Lynch, Ellwood, Slevin, Deltaes, 1987). Others acknowledge this group role, noting that while the group process in some cases is the establishment of social links, insight learning appears to be the most pervasive component (Lieberman, 1988). Based on this process, Parsonnet and O'Hare (1990) have developed a brief family group intervention for cancer patients and their families utilizing former patients as information providers in orientating first time admissions to the cancer centre. As a general rule, support and therapy groups designed for cancer patients and their families are brief interventions, primarily utilized during periods of crisis (Berger, 1984) and attended for an average of two to three sessions (Cobau, 1981).

Although the brief therapy model lends itself easily to either a problem or solution focused therapeutic model, it is solution focused family therapy which best fits the disease itself. Solution focused therapy is a model which has its emphasis on creating change (de Shazer, 1985, 1991). Conceptually this therapeutic model takes a systemic view of the problem and examines interactional patterns. The emphasis on changing interactional patterns is seen as an avenue for solution development. This fits well with assessing the skills of the family to re-establish homeostasis in the system since interactional patterns such as open communication and complementarity in sharing roles and responsibilities have direct implications for the system's abilities to accomplish crisis resolution. Focusing on change as a key to intervention provides an opportunity to identify and influence potentially dysfunctional relationships.

Solution focused therapy is seen as a mutual endeavour involving the therapists and clients together constructing a mutually agreed upon goal. This model goes one step further than the focused problem solving model since its boundaries include the therapist, and its

aim is to describe exceptions to the rule of the complaint, thus intervening to help the client do more of what has already worked (de Shazer, 1988 & 1991). Clients are very aware of problems that occur and see them as always happening. They overlook the times when, in exception, the problem may be absent. For the client, the problem is seen as primary, while the exception is seen as secondary. Therapists view the exceptions as primary, and the problem as secondary. Interventions are meant to help clients make an inversion, which will lead to the development of the solution.

A solution focused approach to brief therapy is suited to cancer care as a model for practise because the nature of the disease is such that crisis is intermittent throughout the coarse of the illness. That is, not only is there a pre-morbid history of coping but there are long periods of time over the coarse of the illness when the family copes. The therapist and family are therefore given immediate access to information which may be required for resolution of the crisis. In effect, one may ask "what was going on at the time that worked?" One of the roles of social work in an oncology setting is to

empower clients at times when they may be feeling powerless in the context of this illness. Solution focused brief therapy serves to empower clients through active utilization of the client's present life resources and images of future goals and possibilities. Rather than focusing on the problem, solution focused brief therapy uses exceptions to the problem as a clue to finding solutions.

Berger (1989) describes a professionally run support group for cancer patients and their families as a form of crisis intervention. The "Coping with Cancer" Family Support Group was developed with crisis theory as its basis with the view that families are being exposed intermittently to the potential for crisis and the belief that before the crisis occurred, the family was functional. The general philosophy of the group is solution focused with an emphasis on strengthening existing adaptive behaviours and coping responses. The "coping with cancer" group also shares many of the tenets of brief therapy and crisis intervention including the time-limited, readily available and flexible nature of the group, the belief that the crisis belongs not only to

patients but to the family and social system, the idea that the identified period of crisis or need for help is defined by the family, a focus on the here and now, and a philosophy of change through learning.

In general, however, solution focused brief therapy intervention studies have not been widely reported in the literature. Miller (1992) presented a series of case studies using solution focused therapy to successfully treat a variety of syndromes including depression in an intermittently hospitalized psychiatric patient, bed wetting, alcoholism, and couple communication. Aspects of the solution focused model were also successfully employed as early as 1983 by Christensen to alleviate the psychosocial complaints of couples following mastectomy. Christensen was able to successfully influence sexual satisfaction scores and reduce psychological discomfort in four brief sessions by concentrating on the pre-morbid strengths and abilities of the referred couples. In another single subject study, Roberts, Elkins, Baile, Jr., and Cox (1989) reported on a breast cancer patient with mastectomy whose two year history of depression was resolved when it was determined through solution focused

sessions that her medication was having a depressant effect. The findings made by these authors, who have used brief therapy and a solution oriented approach with families, have established this model as an effective method of family focused intervention.

It is apparent, given the literature available, that cancer has an enormous impact on the entire family system when an individual is diagnosed with this disease. The crisis response which follows diagnosis and which surfaces intermittently throughout the coarse of the disease extends beyond the individual to each family member. These upsets within the family system commonly means that roles and relationships within this system require reorganization. If communication or information fails the family will not adequately cope and the stage will be set for additional stressors and more frequent crisis. Added expectations, that families should be capable of negotiating the medical system and the social repercussions associated with the disease, further produce additional stressors. It is important that the therapist uses a model of practise that responds appropriately to these unique problems which develop in

families following a diagnosis of cancer. Understanding the issues experienced by families, which include role confusion and relationship changes, miscommunication, isolation and dissatisfaction with the provision of information, places an expectation that therapy be responsive to needs as they arise intermittently over the coarse of the disease. Brief goal-directed interventions that are solution oriented and which remain flexible while continuing to empower the client system ensure positive outcomes in a timely and cost effective manner.

Communication/Language

Language Games and the Concept of System

Solution focused brief therapy sees the therapy system as a set of **language games** (de Shazer, 1985, 1988, 1991). Language games are complete and can only be understood within the context of the pattern of activities involved. The therapeutic relationship is a negotiated, consensual and cooperative endeavour in which the solution-focused brief therapist and client jointly produce various language games focused on (a) exceptions

(b) goals, and (c) solutions. The language system, the communication between therapist and client, has attributes similar to those of any other system.

The **concept of system** is an important consideration when thinking about solution focused brief therapy. According to Auerswald (1987) the five paradigms which have developed in family therapy are the psychodynamic paradigm, the family system paradigm, the general systems paradigm, the cybernetics paradigm, and the ecosystemic paradigm. Each of these are based on a different definition of family system. These paradigms view the family as client, taking an explanatory perspective and creating a barrier between the therapist and family. When taking an explanatory perspective, much is lost in terms of the language of communication that takes place between the therapist and the client in the therapeutic situation. De Shazer (1991) describes the "language game" which goes on in therapy as involving the client and therapist equally, and as a significant part of the therapeutic intervention process. He describes a sixth paradigm that should be added, the "therapy situation as a system" (de Shazer, 1982a, 1982b, 1985, 1991). This

paradigm defines the system under consideration as involving the construction of a purposeful system composed of (a) the therapist subsystem, (b) the client subsystem, (c) the problem to be solved and/or the solution to be developed, and (d) the interactions and interrelationships between and among the first three.

The Concept of Misunderstanding

The **concept of misunderstanding** is used in the therapeutic process where the therapist and client together construct a reality that is more satisfactory to the client by putting together various misunderstandings (de Shazer, 1991). Borders between concepts cannot be depended on so when misunderstandings are agreed upon, behaving as if the new meaning is stable prevents any relapse into old concepts. Intervention at the end of the session is designed to impose an external constraint, so there is no slippage of meanings.

Therapeutic Conversation

According to de Shazer (1991), there is an advantage

to conceptualizing therapy conversations as story construction since it allows for comparison and evaluation of narrative structures of different types of therapy. Three narrative types (Gergen and Gergen, 1983 & 1986) are used in solution focused brief therapy for analysis of therapeutic conversations. These are progressive narratives, which seek desired change; stability narratives, which seek no change; and digressive narratives, which seek undesirable change. The type of narrative that dominates the therapeutic conversation will determine necessary interaction from the therapist to ensure a solution focused theme. According to de Shazer (1991) it is important that precision changes are certified by the therapist as worthwhile or the client may have difficulty experiencing changes as authentic.

Achieving Goals

Using a solution focus, the therapist should open an interview with "What is better?" rather than "How did the homework go?". De Shazer (1991) believes this will expand the range of possible progressive narratives to

include anything the client views as making their lives more satisfactory. What the client comes to see as worth describing is influenced and shaped by the therapist's part in the dialogue. **Goal achievement** provides a major theme for how clients and therapists organize descriptions of change and solutions. Once clients are confident the goal has been achieved and changes are likely to continue, both the therapist and client can know that they can stop meeting.

The Concept of Cooperation

Client resistance in the therapeutic situation is accepted and encouraged in a constructive way. Accepting non-performance of a task as a message about the client's way of doing things allows for developing a cooperative relationship between therapist and client (de Shazer, 1991). The steps in implementing the **concept of cooperation** involve connecting the present to the future and ignoring the past (except past-successes) complimenting the clients on what they are already doing that is useful and/or good for them, and then once they know the therapist is on their side, suggesting something

new that they might try. What clients actually do to make things better is more important than task performance.

The Concept of Difference

De Shazer (1991) also believes that the concept of difference in solution focused brief therapy is an important therapeutic tool since it allows for flexibility and creativity in the therapeutic situation. Differences that are significant to the client are the signatures of difference put to work. This goes back to the pragmatics of practice which require the therapist to find some element in the client's story that allows for intervention which will make a difference to the client and lead to change. De Shazer (1991) states that failure in therapy most often involve inability to negotiate an answer to the question, "How will we know when we can stop meeting like this?" (p. 158). The absence of the complaint is not goal enough since absence cannot be proven. However, success or failure can be proven. Unless clearly established through negotiations beforehand, even the presence of significant change is

not enough to prove the absence of the complaint. Some failures relate to difficulty shifting from a problem focused language game to a solution focused language game. When a digressive or stability narrative develops rather than a progressive narrative, it can result in failure. Failure is both the fault of therapist and client. The therapist has failed to help the client see exceptions as "differences" that can make a difference.

The Main Principles of Practice

Solution focused therapy has seven main principles of practice which may be summarized as follows (de Shazer et al, 1986):

1. Individuals are skilled in learning and developing interactional patterns. These interactional patterns are the source of most complaints. Solutions to complaints lie in changing interactions in the context of the unique constraints of the situation.

2. When constructing a solution it is beneficial to

find out as much as possible about the constraints of the complaint situation and interaction involved because the intervention needs to fit within the constraints of that situation in such a way as to allow a solution to develop. This does not mean that the intervention needs to match the complaints. Only that it opens a way to a solution which can be developed without knowing all the details of the complaint.

3. It is believed that most people who enter therapy want to change and are prepared to be very cooperative. Therefore, when clients find that the ideas for change do not fit very well with them, they are not labelled resistant. Using solution focused therapy, this type of response is viewed as the client's way of letting the therapist know how to help them. The therapeutic key used to promote cooperation is:

> "First we connect the present to the future (ignoring the past, except for past successes), then we point out to the clients what we think they are already

doing that is useful and/or good for them, and then-once they know we are on their side-we can make a suggestion for something new that they might do which is, or at least might be, good for them." (de Shazer, 1985 p. 15).

Using this therapeutic key, therapists avoid labelling clients as resistant or noncooperative.

4. New and beneficial meaning(s) can be constructed for at least some aspect of the client's complaints, and the meaning the behaviour (or sequence of behaviours) is given depends on the observer's construction or interpretation.

5. Only a small change is necessary because a small change can lead to other changes as well as further improvements. The view is that the bigger the goal, the harder it will be to establish a cooperative relationship, and the more likely that the therapist and client will fail.

6. Change in one part of a system leads to changes in

the system as a whole. Therefore, the number of people who are successfully constructing the problem and the solution does not necessarily matter in therapy. However, while it is not necessary to have the whole family present, an individual change does need to fit within the constraints of the system.

7. Even when the therapist cannot describe what the client is complaining about, it is still possible for therapy to be effective. What becomes important is that the person in the troublesome situation does something different, since different behaviour is sometimes enough to prompt solution development. Basically, all the therapist and client need to know is "How will we know when the problem is solved?". An intervention message to successfully fit is then developed without full knowledge of the complaint.

Techniques For Therapeutic Intervention

Client-Therapist Relationships

According to de Shazer (1985, 1988) the client-therapist relationship falls into three categories, the "visitor type" relationship, the "complainant type" relationship and the "customer type" relationship. These categorizations provide a description of what goes on between the client and therapist. However, the therapist must always remember that the character of the relationship can be continually changing. The potential for movement from one type of relationship to another makes it important to be conservative when assigning tasks in order to avoid client failure.

A **visitor type relationship** is one in which the client and therapist have been unable to formulate a problem, complaint or goal and the client had no real desire for change and solution. With this type of relationship the therapist gives positive feedback about what is going right, acknowledges the difficult time the client is having and offer the client a follow-up

appointment which may or may not be accepted.

In a **complainant type relationship** the client and therapist have been able to formulate the beginnings of a goal, and some expectation for change and solution but, the client lacks commitment to, or is unclear on how to take steps to solve the problem. With this type of relationship, the therapist offers positive feedback about what the client is doing right and gives the client an observational task. This type of task is selected because a lack of commitment is evident and the client is less likely to fail with this type of task.

A **customer type relationship** is one that by the end of the assessment phase, the client and therapist have together constructed a complaint, including the beginning of a goal and some expectations of solution. The client has also expressed a willingness to take action and do something to find a solution to the problem. With this type of relationship the therapist offers positive feedback and gives a behavioral task combined with an observable task, asking the client to notice change. In the follow-up session it is the behaviour change and not

the completion of the task which is given attention.

The Miracle Question

From a solution focused therapy perspective, a workable goal involves looking at what will be present in the clients' lives when the complaint is absent and they no longer depict life in problematic terms. In 1984 the concept of **"the miracle question"** was proposed as a way to set a frame for goal setting (de Shazer, 1988). The concept allows clients to bring more non-problem experiences into the conversation and implies that goals developed from miracle questions need not be limited to the problem/complaint. The miracle question is usually asked in the following way:

> "Suppose when you go to sleep tonight, a miracle happens and the problems that brought you in here today are solved. But since you are asleep, you don't know the miracle has happened until you wake up tomorrow; what will be different tomorrow that will tell you that a miracle has happened?" (de Shazer, 1988, p.5).

Initially, clients are asked to pretend that the miracle has happened, making it easier for them to start talking about solutions. Since the miracle question requires no explanation, it is thought that the question allows the client to develop solutions separate from the problems. By helping the client elaborate with follow-up questions, therapists find that responses typically describe the solution in detailed behavioral terms. The more elaborate the descriptive responses, the greater the number of possibilities for taking small steps toward solving their problems.

The miracle question is used with either individuals or relationships. In the case of the individual, clients usually describe changes in everyday events or as the absence of the problem. Whether the client views the problem as theirs or someone else's will influence the way in which the therapist phrases follow-up questions. In the case of relationships, each of the involved individuals may see the problem differently and often hold the other at fault. Possibilities for solutions in relationships can be explored using the miracle question by first changing the focus from blaming to identifying

what the clients have in common in terms of what they want to see happen. Pretending the miracle has happened is a particularly effective strategy when working with relationships since pretending serves to down-play "blaming" and allows everyone in the relationship to save face.

Follow-Up Questions

After the miracle question has been asked and all possible differences are explored, **follow-up questions** are used to help establish exceptions that are related to the goals (de Shazer, 1988). These follow-up questions serve to create a bridge from pretending the miracle has happened to helping the client make it happen. The implication is that the clients have already begun to solve their own problems. Answers to the miracle question and follow-up questions help establish goals, help determine the client-therapist relationship for the client, and when working with more than the individual, assists the therapist in determining who in the relationship is more invested in creating change.

Scaling

Scaling questions also follow the miracle question. These questions are used to measure the client's progress before and during therapy, to determine the client's investment into changes, to determine the client's confidence in taking steps to solve problems, and to assess any perceptions change of relationships or solutions (de Shazer, 1991). Scaling questions can be used even when the problem is vague or unknown by encouraging the client to put vague descriptions into numbers which are not in themselves, particularly important. Rather, the importance lies in the responses to the questions which are to follow since these ask for an explanation about how the rating was decided and what would change if the rating changed. In the case where change has begun to happen for the client, the therapist uses the scaling question to determine the client's level of confidence that change will continue and his/her level of commitment to try something different to reach a solution.

Therapeutic Assessment

De Shazer et al (1986) and Molnar and de Shazer (1987) have described the format for therapist intervention using the solution focused brief therapy model in the initial and subsequent sessions. The first session takes less than an hour and follows the following format:

1. The client(s) is introduced and orientated to the therapeutic procedure.

2. The first order of business occurs when the therapist asks the client(s) about the complaint i.e. "What brings you in?" The therapist attempts to direct the conversation to obtain as much concrete detail as possible. The greater the amount of detail, the greater the potential for identifying interventions and goals.

3. This phase of the interview focuses on "exceptions to the problem" and is designed to determine what happens when the complaint is absent. The

discussion around "exceptions" not only clarifies client behaviours that are effective, but also gives clients the message that they are already doing things that are positive. This leads to the phase of goal setting.

4. Goal setting provides a measure of the efficacy of therapy and, more importantly, helps build the expectation that change will occur. Setting goals also lets everyone involved know when the problem is solved and therapy can stop.

5. This step in the interview focuses on solution development. Conversation centres around how clients will know when the problem has been solved and what will be different when the problem is part of the past. The aim is to have the majority of conversation throughout the session focus on the absence of the complaint.

6. After thirty to forty minutes an intermission is taken and the therapist leaves the client alone. The purpose of this intermission allow the

therapist to develop messages consisting of compliments and clues. Compliments support the orientation toward solution and let clients know that the therapist sees things their way and agrees with them. Clues are focused therapeutic suggestions, tasks, or directives for the client that will lead in the direction of solution. Behavioral tasks are common and may include formula tasks for complaints to which continue to lack definition. The formula task may be given, verbatim, as follows:

> Between now and the next time we meet, we would like you to observe, so that you can describe it to us next time, what happens in your life that you want to continue to have happen (De Shazer et al, 1986, p.217).

According to de Shazer et al (1986) the formula task has been documented has having a high success rate.

7. Upon returning to the session from the intermission the therapist quickly (within approximately five

minute) delivers the intervention message and ends the session.

Second and subsequent sessions follow a similar format and also require less than one hour. With the complaint already covered in the first session, the therapist's first order of business in second and subsequent sessions is to focus conversation on what happened with the clients that they want to have continue. The therapist listens for anything clients can list as worth continuing and identifies and comments on them. If the client reports that the previous intervention "fit" and led toward solution, the goal of therapy becomes helping the client continue making changes. If the client reports that the intervention did not "fit", the therapist returns to questions of "What is it that the client is doing that is working?" An intermission is used in all sessions and a message is formulated and delivered using compliments and clues. Follow-up sessions are scheduled less often if there is report of improvement in the clients' lives.

CHAPTER THREE

PRACTICUM PLACEMENT DESIGN AND EVALUATION

Practicum Placement Design

Setting

The practicum placement was completed at the Department of Social Work, Oncology Unit, St. Boniface General Hospital, Winnipeg, Manitoba. The goal for the social worker in this Program is to assist cancer patients and their families to cope with the psychosocial effects of cancer within the framework of a multidisciplinary team approach. Various oncologists, nurses, social workers, and a chaplain are members of the multidisciplinary oncology team.

Clients

The client population for this practicum consisted of families of adult cancer patients. Referrals to the Department of Social Work are accepted from hospital sources (e.g. medical staff, nurses, other helping professionals) and from families themselves. In this case, all of the families seen were referred by nursing staff.

To develop a better understanding of the problems experienced by spouses of cancer patients, this practicum focused on families where the spouse was identified with the presenting problem. Intervention was provided to six families selected from the referrals to the Department of Social Work. Identified problems included caregiver overload, issues of grief and loss, family stress and anxiety, palliative care, death of patient and limited supportive resources. Table 1 provides a description of the families who participated in therapy during this practicum.

Personnel

The writer was the primary therapist in all cases included in this practicum. Clinical supervision was provided by Professor Ranjan Roy, M.S.W., Faculty of Social Work, University of Manitoba, and by Jill Taylor-Brown, M.S.W., Social Worker, St. Boniface General Hospital. Supervision was held weekly and included discussion, case planning and audio tape reviews. The writer also attended regularly scheduled Psychosocial Oncology Rounds, Pathology Rounds, Inpatient Unit and

TABLE 1

Summary of Family Types, Presenting Problems, Number of Sessions and Weeks of Therapy

Family	Type	Presenting Problem	#Ses	#Wks
A				
patient	intact	male patient (57)	8	12
spouse	family	palliative stages		
3 dtrs		family conflict		
B				
patient	retired	male patient (71), palliative stages	4	11
spouse	couple	limited social support for family		
C				
patient	retired	male patient (77), palliative stages,	3	3
spouse	couple	grief reaction		
D				
patient	retired	male patient (67), family stress	4	8
spouse	couple	resulting from disease crisis		
E				
patient	retired	female patient (71) with unstable health,	4	2
spouse	couple	caregiver overload, developmentally challenged daughter (32)		
F				
patient	intact	male patient (40), palliative stages,	4	3
spouse	family	caregiver overload		
2 children				

Palliative Care Unit Rounds, and Social Work Staff meetings. External supervision of the practicum was provided by Dr. Joe Kuypers, Faculty of Social Work, University of Manitoba.

Procedure

A solution focused brief therapy interviewing and interventive strategy was utilized. In-hospital interviews took place in interviewing rooms or in patient's room on the unit. On two occasions families were seen in their own home. Sessions were audio taped only when consent was given by clients. Interviews were approximately one hour in duration and appointments were scheduled to best meet the needs of each client in terms of travel flexibility and therapeutic goals. Travelling to appointments was an issue only for those clients living in rural Manitoba. Where possible, appointments coincided with the cancer patient's admission to hospital, or attendance at the outpatient oncology clinic.

All families were requested to complete and participate in the evaluation mechanisms of the practicum. This included the completion of a pre and post test measure (FAM III) (Appendix A), and an ongoing measure in the form of a self-anchored scale (Appendix B). Clients were also asked to participate in a

debriefing session upon termination of treatment. This provided a format for families to discuss their experiences while in therapy and provided direct consumer feedback (Client Satisfaction Questionnaire) (Appendix C).

Duration

The practicum ran for three and a half month from April 13, to July 16, 1993.

Recording

Recording followed the standards and format set out by the Department of Social Work, St. Boniface General Hospital. The initial assessment included relevant background information, identification of presenting problems, an assessment of family functioning, and the proposed treatment plan. The records also contained a solution focused brief therapy assessment with the focus on critical dimensions of the client-therapist relationship, problem or complaint, and goals for solution. Therapy notes were kept up to date with each

family therapy session. The record of therapy results have been included in hospital records and are incorporated into the practicum report. Client progress was evaluated at each session based on both the therapist's and the client's perception.

Evaluation

Criteria for Evaluation

Evaluation is a necessary component of sound social work practice, and is important for determining and demonstrating the effectiveness of treatment. Therapists are ethically compelled to provide effective, cost effective treatment that has no known detrimental effects. However, according to Proctor (1990), Richey, Blythe and Berlin (1987) practitioners do not routinely evaluate their practice. A number of barriers have been identified as contributing to the lack of evaluation (Douech & Bondanza, 1990, Richey et al, 1987). Limited knowledge, time, agency support, available measures and inadequate evaluation skills all contribute to a lack of clinical evaluation practices in the field.

In addition to the usual barriers to evaluation, family centred practices focus on a complex system which poses additional difficulty. Treating a complex system with many different behaviours requires the use of a measurement package that is sensitive to the problems of this dynamic system. According to Bloom and Fischer (1982), using multiple measures allows the practitioner to increase reliability, validity and utility. Dawson, Klass, Guy and Edgley (1991) also support this view.

Method of Evaluation

Multiple measures were used to evaluate this practicum. This measurement package provided a means to evaluate the outcome of treatment and skill development of this practitioner. Measures used in this practicum are described in detail in the following section.

A "B" pre and post-test research design was utilized. The Family Assessment Measure, General Scale (Skinner, Steinhaves & Santa-Barbara, 1983) (Appendix A) was the primary measure used to collect data on family functioning immediately prior to and after completion of

therapy. Secondary measures included a scaling question (de Shazer, 1991) in the form of a client self-anchored scale (Bloom & Fischer, 1982) (Appendix B), and a therapist rating scale (Bloom & Fischer, 1982) (Appendix B) to be used in each session. These measures collected data on problem change during intervention at each session. A client debriefing session, at the end of therapeutic intervention included a Client Satisfaction Questionnaire (Larsen, Attkinsson, Hargreaves & Nguyen, 1979) (Appendix C). Demographic information about the client system was obtained from the hospital chart. In addition to feedback relevant to the therapist's performance obtained from the consumer in the debriefing session and on the Client Satisfaction Questionnaire, the Family Therapist Rating Scale was to be completed by the primary supervisor midpoint and the end of the practicum.

Primary Evaluation Instrument

1. The Family Assessment Measure (FAM) (Skinner et al., 1983) (Appendix A) is a self report instrument that provides quantitative indices of family strengths and

weaknesses. The basic concepts assessed by FAM are: task accomplishment, role performance, communication, affective expression, involvement, control, values and norms. The measure provides Canadian norms and has high reliability and validity in discriminating between clinical and non-clinical families (Skinner et al, 1983). The FAM takes about 20-30 minutes to administer and may be used as a clinical diagnostic tool, as a measure of therapy outcome, or as an instrument for basic research on family processes.

a. The FAM General Scale is composed of fifty items. This scale uses a systems perspective and focuses on the level of health pathology in the family. It has an overall alpha score of .93 for adults and .94 for children, demonstrating strong internal consistency and with each sub-scale reliability having moderate-to-high scores.

Secondary Evaluation Instruments

1. The scaling question (de Shazer, 1991) (Appendix B) rates goal attainment via a self anchored scale (Bloom &

Fischer, 1982). It has the advantage of being appropriate for repeated use and can be tailored to match the client system.

2. The therapist rating scale (Bloom & Fischer, 1982) (Appendix B) rates client goal attainment from a different perspective. The rating scale facilitates comparison of the level of agreement between client and therapist, and acts as a mechanism to ensure therapeutic goals fit with the client.

3. The debriefing session, provided each client system the opportunity to describe and discuss the therapeutic experience and share information about what was and was not helpful. Clients were asked to complete the Client Satisfaction Questionnaire (Larsen et al., 1979) (Appendix C) as a means of facilitating this process.

Tertiary Evaluation Instrument

1. The Family Therapist Rating Scale (Piercy, Laird & Mohammed, 1983) is a standardized measure intended for training therapists. The scale can discriminate between

experienced and inexperienced family therapists. Inter-rater reliability and internal consistency of the categories are judged to be acceptable. Crohbach's alpha reflects relatively high internal consistency for each of the five sub-scales, ranging between .72 and .95. This scale has relevance for many therapeutic models, including those developed by Watzlawick, Weakland and Fisch. The solution-focused brief therapy model has drawn its knowledge base from concepts developed by these authors (O'Hanlon, Weiner-Davis, 1989).

Supervision

Supervision occurred on a weekly basis with Professor Ranjan Roy, M.S.W., Faculty of Social Work, University of Manitoba and with Jill Taylor-Brown, M.S.W., St. Boniface General Hospital.

Client Feedback

All families who received services during this practicum were requested, at the end of therapy, to participate in discussion about their therapeutic

experiences with the therapist, and to complete a Client Satisfaction Questionnaire (Appendix C).

CHAPTER FOUR

PRACTICUM SUMMARY AND CASE EXAMPLES

Introduction

This section provides a general overview of the practicum, describes the practicum process and draws conclusions regarding the utility of the evaluation instruments. Two case examples are provided to illustrate the utilization of the brief family therapy model. Through descriptions of the therapeutic process, the efficacy of the interventive strategy is explored. Clinical observations and the results of the FAM III General Scale, the client self-anchored scale and the therapist rating-scale are included with each case and the correspondence between outcome measures and the family's perception of change is explored.

Practicum Summary

Treatment was provided to a total of six families during the course of the practicum. In some cases only part of the family attended therapy. Absence of family members was attributed to illness and individuals being unavailable. In five of the six families, the cancer patient was male. The individual with cancer in family

'E' was female. Four of the families were retired senior citizen couples who's children, with the exception of one family, were living away from home (Families B,C,D,E). The remaining two intact families had adult children (Family A) and young children (Family F) living at home. Spouses in these two families worked (except when the patient was critically ill) and saw themselves as needing to work to support their family.

Therapeutic goals for each of the six families centred around learning to cope with cancer as an illness. Palliative care was a central factor for four of the families (Families A, B, C, E). A history of problems within the family were cited by only one family (Family A).

Of the six families, only one (Family A) completed all of the evaluation instruments. Three families (Families B, E and F) did not complete the post-test component of the evaluation package and two others (Families C and D) declined to complete both the pre and post-test instruments. At the end of the practicum period, two families (Families B and D) were referred to

other social workers for continued therapy. Family B requested to remain connected to the Department of Social Work, anticipating further crisis as the family member's health deteriorated. Family 'D' continued to have unresolved issues. Further intervention beyond the time frame of the practicum was warranted.

While the families expressed curiosity about the nature of the instruments, none reported undue stress or difficulty in association with the evaluation process. Families completing all or part of the evaluation package supported the principle of evaluating the effectiveness of intervention. One family, (Family A), commented on the therapeutic value inherent in the evaluation instruments. The two reasons cited for non-compliance in completing the post-test instruments included feeling overwhelmed by the patient's illness and experiencing the death of the ill family member. Five of the six families did not complete the FAM III post-test following the death of the cancer patient or while family members continued to experience anxiety over the patient's condition. Table 2 provides a summary of the evaluation instruments given to and completed by participating

family members.

TABLE 2

Evaluation Package: Summary of Evaluation Instruments Given to and Completed by Family Members

Family	FAM III Pre test	FAM III Post test	Client self-anchored	Therap. Rating Scale	Debrief-ing Session	Client Sat. Quest.
A						
spouse (Susan)	*	*	*	*	*	*
dtr (Sarah)	*	*	*	*	*	*
dtr (Lori)	*	*	*	*	*	*
dtr (Anne)	*	*	*	*	*	*
B						
patient	-	-	*	*	* refer	*
spouse	*	-	*	*	* S.W.	*
C						
patient	-n/a	-n/a	-n/a	-n/a	-n/a	-n/a
spouse	-	-	*	*	*	-
D						
patient	-	-	*	*	- refer	-
spouse	-	-	*	*	- S.W.	-
E						
patient (Karen)	*	-	-	-	*	*
spouse (John)	*	-	-	-	*	*
F						
spouse	*	-	*	*	*	*
dtr	*	-n/a	-n/a	-n/a	-n/a	-n/a
son	*	-n/a	-n/a	-n/a	-n/a	-n/a

Note:
* instrument completed
- instrument not completed
n/a not available to participate in intervention or evaluation
refer S.W. case referred for further intervention

The FAM III questionnaire (Appendix A) was found to be a useful measure from a clinical perspective as a result of its apparent sensitivity to detect change over time. This sensitivity is clearly exemplified by Case example 'A'. Marked pre and post-treatment changes for each family member indicates a substantial improvement in perception following intervention. There is incomplete pre and post data for all but one family on the FAM III but the utility of the instrument is considered promising by the therapist on the basis of this case. This will be discussed in more detail in the case review for family 'A'. Pre intervention scores were however available for one or more members of four of the six families participating in therapy. These pre-test scores matched the therapist's clinical impressions about the degree of severity of family pathology. Table 3 provides overall results for each family member attending therapy and completing the FAM III measure.

It is interesting to note that some family members expressed difficulty answering certain questions on the FAM III questionnaire. The reason given was that they felt questions were irrelevant to the crisis they were

experiencing. It is anticipated that a questionnaire possessing greater face validity relative to cancer might improve completion compliance.

TABLE 3

Overall Score: Pre/Post Test Results Using FAM III General Scale

Family	Subject	Pre-test	Post-test
A	spouse (Susan)	67	47
	dtr (Sarah)	69	34
	dtr (Lori)	62	55
	dtr (Anne)	61	48
B	patient	-n/a	-n/a
	spouse	46	-
C	patient	-	-
	spouse	-	-
D	patient	-	-
	spouse	-	-
E	patient (Karen)	47	-
	spouse (John)	55	-
F	spouse	44	-
	dtr	48	-n/a
	son	45	-n/a

Scores between 25-40 indicate family strengths; 40-60 average range; and 60-75 family problems

Note:
- test not completed
n/a not available to participate

The therapeutic scaling question (de Shazer, 1991) was found to be very useful. This was administered in the form of client self-rating and therapist rating scales (Appendix B). Five of the six families completed this component of the evaluation package. The fact that the scales are designed to be used in each session and are tailored to match the problem specified by the family, makes them particularly useful as a measure of progress over time which is easily comprehensible to the client. In addition, it is the nature of the scales to be directed toward the future, goal oriented and solution focused, to such an extent that they can provide a mechanism which helps to maintain the direction of the therapeutic process.

Table 4 provides an illustration of first and final session scores for the client self-anchored scale and the therapist rating scale. The magnitude and direction of change in functional level, as perceived by the client and by the therapist, is noteworthy. All families for whom scaling questions were used experienced change in the positive direction as perceived by both the client system and therapist. Within family 'A', it is also

interesting to note that the individuals experiencing the greatest degree of change are also those for whom the FAM III indicated the most marked pre and post treatment differences.

The Client Satisfaction Questionnaire (Appendix C) utilized at termination also provided useful feedback regarding the therapy process. All of the four families completing this questionnaire (Families A, B, E and F) reported satisfaction with the service provided. They indicated having received the services they wanted and that these services had met their needs. Family members further reported that they would seek out these resources again if needed and would not hesitate to refer others. No family reported statements or actions that where not helpful. While feedback from the Client Satisfaction Questionnaire was positive, it would have been useful, from the therapist's perspective, to obtain commentary which would assist in discriminating between aspects of intervention found to be helpful or unhelpful.

TABLE 4

Therapeutic Scaling Question: First and Final Session Scores of Client Self-anchored and Therapist Rating Scales

	Client Self-Anchored Scale		Therapist Rating Scale	
Family	First Session	Final Session	First Session	Final Session
A				
spouse (Susan)	5	8	5	8
dtr (Sarah)	2	7	5	6
dtr (Lori)	6	7	6	6
dtr (Anne)	7	8	5	7
B				
patient	6	7	5	7
spouse	6	8	6	8
C				
patient	-n/a	-n/a	-n/a	-n/a
spouse	7	8.5	7	8
D				
patient	4	6	4	5
spouse	5	7	6	7
E				
patient (Karen)	-	-	-	-
spouse (John)	-	-	-	-
F				
spouse	6	7	6	7
dtr	-n/a	-n/a	-n/a	-n/a
son	-n/a	-n/a	-n/a	-n/a

Scales rated 1 - 9 with large numbers meaning situation perceived as improved.

NOTE: Client Self-anchored Scale: client's perception.
Therapist Rating Scale: therapist's perception.
-: scaling questions not utilized ie not appropriate or member did not participate in therapy session.
n/a: not available for intervention or evaluation

Case Examples

Case examples are illustrated for two of the six families that participated in therapy. These cases were selected by their representativeness of the client group participating in this practicum. Family 'A' illustrates the influence that a diagnosis of cancer has on a relatively young family with dependant children, while Family 'E' illustrates the effects of this disease on a family in their senior years. These case examples are representative of families participating in therapy throughout the practicum period. These two cases also provide clarity in presenting the solution focused model in a context where it can best be understood and evaluated with this client population. Techniques of the solution oriented model are utilized within each case illustration. Applying the concepts and techniques of the solution focused model appeared most successful with Family 'A'. However, application presented a greater challenge while intervening with Family 'E'.

In each of these cases' the assessment, intervention and outcome phases are identified. An initial

assessment, including an assessment of family functioning, was made within the first, and in some cases, the second session. Initial assessments that took two sessions were the result of family members being unable to participate in the first session. The purpose of the assessment phase is to define the client's goals for therapy and generally consists of the client's statement of the problem and the development of a miracle picture. As the client develops a miracle picture, treatment goals for therapy emerge. It is important to note that the problem presented by the client and the miracle picture are not necessarily related.

Intervention is the phase where clients begin to realize their goals. The role of the therapist is to help the client discover how these goals can be accomplished and what can be done differently. Intervention begins as early as the first session. Strategies for therapy following a solution oriented approach which include maintaining rapport, the use of miracle and scaling questions, compliments, understanding and acceptance of each individual's world view, searching for exceptions and amplification of strengths and

abilities. Strategies are utilized during assessment to help the client define goals for therapy and during intervention to facilitate change. Clients may be assigned tasks to facilitate goal accomplishment so therapy can move towards termination.

The outcome phase is the point at which the situation improves to a level perceived as satisfactory by the client. This can commonly occur as early as the second or third session. Each session after the first begins with the therapist asking "What's better?". If the client is satisfied that the situation has improved to an acceptable point, therapy will come to an end. If the client believes further change is warranted, therapy will continue.

Case Example One: Family A

Susan (51) was referred by the Palliative Care Unit's Liaison Nurse. According to the Liaison Nurse, Susan was having difficulty managing the symptoms of her husband's cancer diagnosis at home as a result of the stress in the family. When approached by the nurse,

Susan agreed that a referral be made to the Department of Social Work. Susan was contacted and an appointment arranged.

Assessment

Susan is married to Jim (57) and together they have three daughters. Sarah (24) and Anne (19) live at home, and Lori (22) is living on her own. Susan works for her brother in his business. Jim had worked as a salesperson and was away much of the time. Jim was first diagnosed with cancer of the colon approximately five years ago. One year ago he was again diagnosed with cancer in the abdomen and with liver metastases. Jim was forced to stop work following the most recent diagnosis. At the time of this referral he was at home being cared for by Susan during the final stages of his illness.

Part I: Client's Statement of the Problem

The first session was attended by Susan alone. Susan spoke openly, giving a detailed history of the ongoing conflict in her marriage and describing the

present state of affairs within the family now that Jim was terminally ill. Susan spoke in practical terms and avoided any expression of emotion. Susan stated that she and Jim had a difficult marriage and, in many respects, separated themselves from one another more than ten years ago. Susan blamed Jim for the existing conflict and stress in the family. She expressed feeling "overloaded" as a result of working full-time and caring for Jim. According to Susan, Jim's death would be a welcome end to the problems between them, the conflict within the family. Susan took little responsibility for any marital problems and Jim was targeted as a scapegoat for her anxiety and stress. This pattern was effective on a practical level because Jim was seldom present to defend himself. However, on a problem solving level it blocked any motivation for Susan to learn to confront problems.

Appearing to use caution, Susan shared her personal experience of the losses in her life. A sister and her mother both died of cancer during different periods of Susan's late teen and early adult life. More recently Susan's seventy year old father died suddenly of a heart attack. The failure of her marriage ten years ago has

been another loss for Susan, and now her husband was dying of cancer. When queried, Susan seemed emotionally disengaged, denying any relationship between previous personal losses and the existing stress she was experiencing.

Susan described the relationship with her daughters, Sarah, Lori and Anne, as being ones of friendship. However, she appeared frustrated and confused because her family seemed to be arguing more than usual. Recently, Susan has been "at odds" with her children, expecting them to take a more active role in caring for Jim. With the breakdown in Susan's marriage, she depended upon the relationships with each of her daughters. These dependant relationships became subsystems with rigid boundaries, emotionally isolating the children from one another and from peers.

Although Sarah and Anne lived with Susan, and Susan saw Lori almost daily, she never questioned her daughter's abilities to cope with Jim's illness before today. Rather, she assumed her children welcomed Jim's death, as she did. The possibility that her children

might be finding it hard to cope with their father's illness seemed a new concept to Susan, one she had not previously considered.

During the assessment phase Susan focused on relationship issues between immediate family members and on past relationships with family members who died. Initially Susan described the presenting problem as stemming from a history of Jim's negative behaviour towards his family. She believed this was the reason for any family conflict and for the stress she was experiencing. The problem statement was accepted and acknowledged by the therapist. While this information was important in building the therapeutic relationship, no effort was made to elaborate on the problem statement.

Part II: The Miracle Picture

As a method of facilitating the development of Susan's goals in the assessment phase, Susan was asked the "miracle question". If a miracle happened tonight while you were sleeping what would you notice the next morning that would be different? Susan said that Jim

would have died, that she would be confident that her daughter's were not "damaged emotionally" by his death, and that her daughters would be capable of managing on their own.

Susan was encouraged to elaborate on the meaning of these "differences". She explained that once her husband died, their family life would improve because Jim, who she believed was responsible for the problems within the family, would be gone and the relationships between herself and her daughters would become stronger. Arguing would decline and their friendships would strengthen. Susan also explained that each of her daughters seemed too dependant upon "staying close to home". She felt that her children's lack of confidence and dependency resulted from family conflict brought on by their father while they were growing up. Susan expressed anger at Jim for having caused so much grief. She would know that her children could manage on their own when they had stable jobs and some direction in their lives. Susan felt this would also let her know she had been a good parent. Susan wondered if her daughters must resolve any differences with their father before he died in order to

help them feel more independence.

Susan's goals for therapy included Jim's death, that would serve to end a marriage that in many ways had ended years ago. Her second goal was to strengthen the relationships with her daughters. The scaling question and techniques of elaboration and highlighting help to further define this miracle picture. Susan was asked the scaling question. On a scale of one to nine, "your perception of how your family is coping", with one being "worse" and nine being "best", where is your family on this scale? Susan indicated "five", stating the stress between herself and her daughters could improve and eventually Jim would be gone from her life. Each family member was asked the scaling question as part of the therapeutic process in the sessions that followed. Family member results are noted in Table 7.

Susan was complimented on having been open about her difficult family history, and on her concern for the future of her children. Her commitment to care for Jim during his illness was noted and her feeling of being overwhelmed was validated. Susan's new awareness that

her children may be having problems coping with Jim's terminal illness, particularly since each were on difficult terms with their father, was noted as an exception given that Susan had not seen this as an issue prior to our session, assuming any problems would be resolved once Jim died.

As the session progressed, the problem first identified by Susan was further defined. Susan felt overloaded in her many roles as spouse, caregiver and income earner. She had difficulty coping with the change in Jim's place in the family from an external position to a centralized position. She also identified stress in the family as a result of learning to cope with past losses and with losing a member, even if the relationship has been distant. In addition, insufficient communication among family members left Susan feeling ambivalent about the strength of relationships within the family.

Susan began to talk more openly and expressed feeling little confidence in her skills as a parent. Susan expressed a sense of urgency to better understand

the needs of her daughters and to be reassured that Sarah, Lori and Anne would make a healthy adjustment when their father died. It was agreed that family members would be invited to participate in future therapy sessions. Susan was given the task of noticing the times when the conflict between herself and her children subsided.

Intervention

The client's abilities to describe the miracle picture, which is part of assessment, can also be understood as the beginning of the intervention phase. In this case example Susan had begun to construct a new reality for herself which, in itself was a first step towards realizing her goals. The client was then supported in her efforts to break the identified goals into smaller, achievable goals. Intervention with this family included a total of eight sessions over a course of twelve weeks. Family members participating in therapy included Susan, Sarah, Lori and Anne. Jim was too ill to attend therapy and died half way through the intervention process. During family sessions two and three, Sarah,

Lori and Anne talked about their own perceptions of the problem. The problems identified were further elaborated and goals for therapy were identified.

Sarah's perception of the problem was similar to that expressed by her mother. She described herself as having low self-esteem and attributed this to how she was treated by her father. Sarah perceived Jim as central to the sadness in her life and indicated that she needed help to remove this sadness from her life. She presented as emotionally disengaged. Sarah expressed hope that her life would improve with Jim's death.

Lori spoke about the arguing and conflict in the family and described it as the reason she moved away from home. She also expressed difficulty watching her father's health deteriorate, and felt uncomfortable around home. Lori reported feeling unclear about what could be changed and found avoiding her parents' home helpful. She was not sure if there was anything anyone could do to help with these concerns.

Anne described herself as feeling rejected by her

father. She felt "stuck" living at home and hopeless about the future. Anne described the problem as lack of caring among family members. She seemed to have no sense for what it might mean to lose her father other than Susan's words of reassurance that life would improve.

Family members were asked the miracle question. Sarah stated she would experience better self-esteem and more certainty about the future. Lori stated she would not feel bad about her father dying and family life would improve. She recalled moving from her parents' home as a time her situation had improved with her family. Anne stated that if a miracle happened she would know because her family would "not fight as much". Anne could not recall a time that she had experienced this difference. Susan's response to the miracle question was unchanged.

Each member of the family was complimented for attending the sessions and for their efforts to improve their situation. Their abilities to share important issues was highlighted in an effort to improve the flow of information at an affective level. Susan was complimented for concern over her children's future.

Sarah was complimented for her willingness to work toward change. Lori was complimented for her openness about her feelings around Jim's illness and as a result, her grief reaction was highlighted and legitimized as a valid feeling. Finally, Anne was complimented for her determination to work toward a more cohesive family unit.

The problems first identified by Sarah, Lori and Anne were further defined as problems of insufficient communication among family members which left them feeling unsupported and in need of some direction about their future. Learning to cope with losing their father was also a problem. These newly defined problems fit with the way Susan, in our first session, had begun to understand the problems she and her family were confronted with.

The terminal stages of Jim's illness had been responsible for creating a crisis within this family system. On a practical level the family functioned adequately while Jim was independent and separated from the rest of the family. However, on an emotional level, family members shared limited information and appeared

isolated. When Jim worked he was seldom home. His communication with the family tended to be conflictual and only served to reinforce boundaries between him and the rest of the family. Feeling unsupported by Jim, Susan looked to her daughters for companionship, behaving as a friend rather than as a parent. A combination of factors, including the breakdown of their parents' relationship, the absence of their father and the relationship with their mother as a peer, left Sarah, Lori and Anne lacking the resources of a parental role model to provide them with direction and address emotional needs. Susan's efforts to align with her children made each of these daughters uncertain about trying to become more independent. These young women learned to keep their feelings to themselves and function in isolation emotionally. Each presented with poor self-esteem and seemed ambivalent about their own futures.

Initially the client-therapist relationships with each family member were ones of a "complainant" type. While members saw themselves as needing to work towards change, they did not seem to know how to confront these problems and begin the process. By the third session,

the client-therapist relationships developed into "customer" types. Having gained new insight about how to address the agreed upon problems, Susan decreased the number of hours at work each week to reduce the overload and all four began to include each other in their communications and to talk more about important feelings.

Susan arranged a bedside session for her family together with their priest prior to Jim's death. Each family member had an opportunity to talk with Jim in his last hours and to reconcile some of their differences. This illustrated Susan's efforts to further her skills in problem solving by taking steps to confront her marital and family problems. As a parent, Susan encouraged the grieving process so that family members could cope more effectively with Jim's death.

The third session revealed that family members felt vulnerable and still lacked the level of trust necessary for the expression of emotion. Sarah and Lori suggested an individual therapy session before again meeting as a family. Susan and Anne were in favour of this. Individual sessions fit with each member's goals for

therapy and created an opportunity to highlight individual strengths.

The individual session with Anne created an opportunity for her to elaborate on feelings of being "stuck" in her family situation. Exceptional times were highlighted and following the session Anne began working part-time to make extra money and increase her freedom.

The individual session with Lori created an opportunity to disclose having had an abortion over a year ago and to work on issues of grief around this loss and that of her father. Lori's effort to confront the grief was highlighted and her feelings were validated. Issues of trust were addressed, leaving Lori to consider whether she would share this disclosure with the rest of her family.

Susan used the individual session to talk about her many losses in greater detail and work on issues around feelings of grief.

The individual session with Sarah was full of tears

and emotion. Feelings of low self-esteem were expressed and strategies to address this issue were discussed. Sarah disclosed that two years earlier she had contemplated suicide. Although she no longer considered this a solution for her problems, sharing the information seemed to lighten the emotional load she carried. There was no evidence that Sarah was at risk for suicide while she was in therapy. Sarah's disclosure was noted as an exception and highlighted as an important step in the healing process.

Outcome

After twelve weeks family members met for the eighth and final session. Sarah and Lori were not present at this session but were contacted by telephone. Family members expressed satisfaction with the therapeutic process and there was general consensus that family functioning had improved. Evidence of improved affective expression was apparent as family members talked openly and reflected on issues of significance. Each of the daughters had begun to pursue peer relationships. They also had taken an active role helping their mother run

Jim's business, and held regular family meetings. Family members agreed that this was an appropriate time for therapy to come to an end.

In this case example the evaluation instruments supported both the family's reports of change, and the therapist's clinical observation. Using the FAM III pre-test, family members scored between 61 and 69 on the overall rating scale, while scores on subscales tended to be high. When intervention with this family terminated, individual members scored between 34 and 55 on the FAM III post-test overall rating scale. Differences in the overall rating scores from pre to post-test indicate changes in individual family member's perceptions of family functioning. According to these scores, members perceive their family to be functioning more effectively by the time therapy concluded. Also, Sarah's scale scores were lower from the onset, approaching average in the pre-test and falling within the strength category in the post-test. Unique qualities, such as being independent and having well established peer relationships, confirm the differences in Sarah's scale scores compared to other family members. Tables 5 and 6

provide a summary of pre and post-test subscores for each family member.

The FAM III pre and post-test profiles illustrated congruence between family members, suggesting that the family shares many common perceptions. However, there is also great variability among member's scale scores. This supported the desirability of the individual sessions that the therapist and the family interjected. Figures 1 and 2 provide pre and post-test FAM III profiles. These profiles were obtained approximately twelve weeks apart.

TABLE 5

Family A: Pre-test Results Using FAM III General Scale

Scale	Susan	Sarah	Lori	Anne
Overall Rating	65	69	62	61
Denial	73	78	63	53
Social Desirability	65	56	65	65
Task Accomplishment	69	88	59	64
Role Performance	63	54	72	68
Communication	59	59	50	54
Affective Expression	66	76	61	56
Involvement	60	69	64	64
Control	36	26	39	41
Values and Norms	33	23	39	27

Note: Scores between 25-40 indicate family strengths, 40-60 average range, and 60-75 family problems

TABLE 6

Family A: Post-test Results Using FAM III General Scale

Scale	Susan	Sarah	Lori	Anne
Overall Rating	47	34	55	48
Denial	43	48	58	53
Social Desirability	47	33	56	47
Task Accomplishment	50	31	50	54
Role Performance	54	30	44	54
Communication	38	38	38	46
Affective Expression	51	31	46	46
Involvement	47	29	47	38
Control	44	33	55	49
Values and Norms	50	39	46	42

Note: Scores between 25-40 indicate family strengths, 40-60 average range, and 60-75 family problems

Figure 1

Family A: Pre-test Profile Using FAM III General Scale

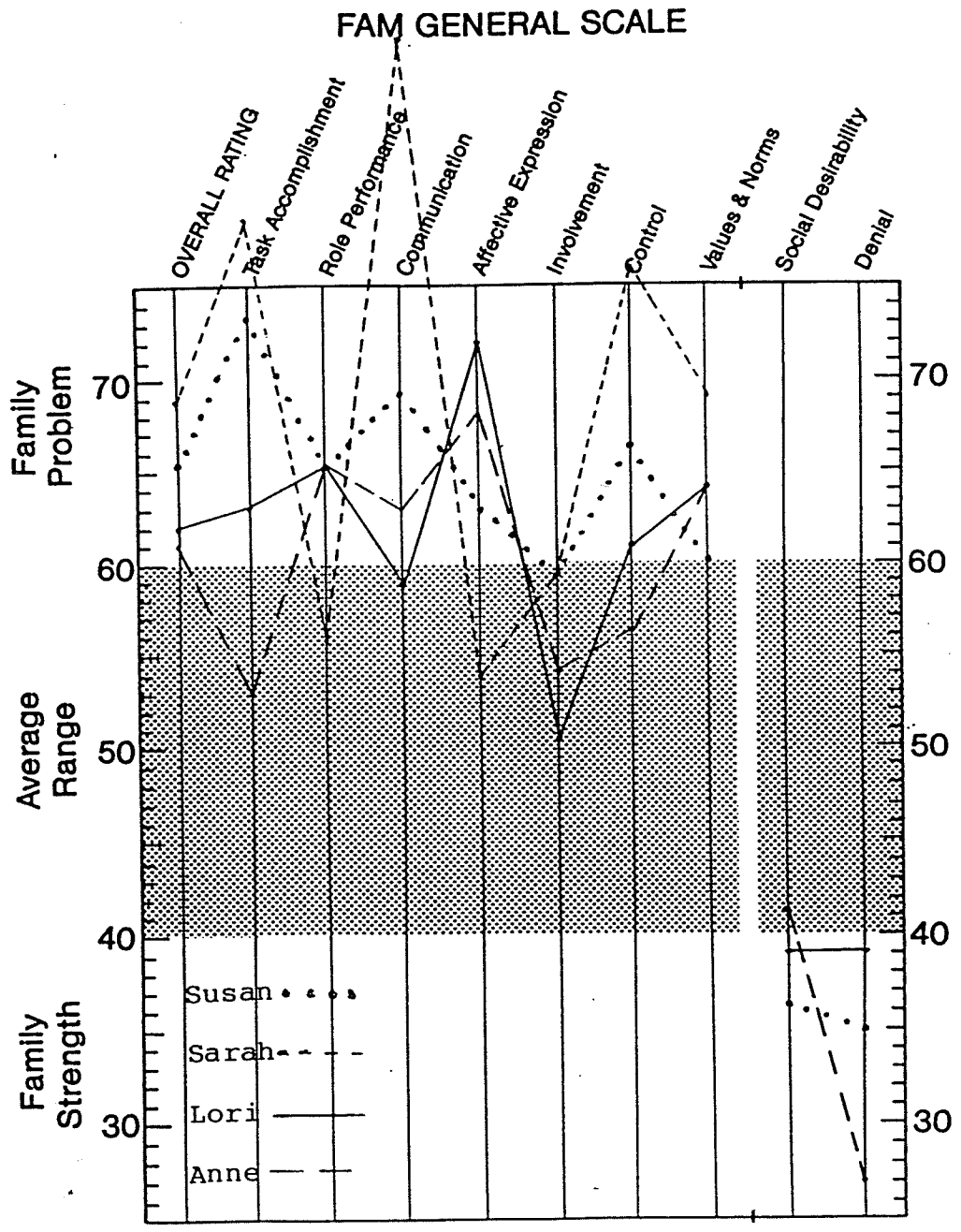
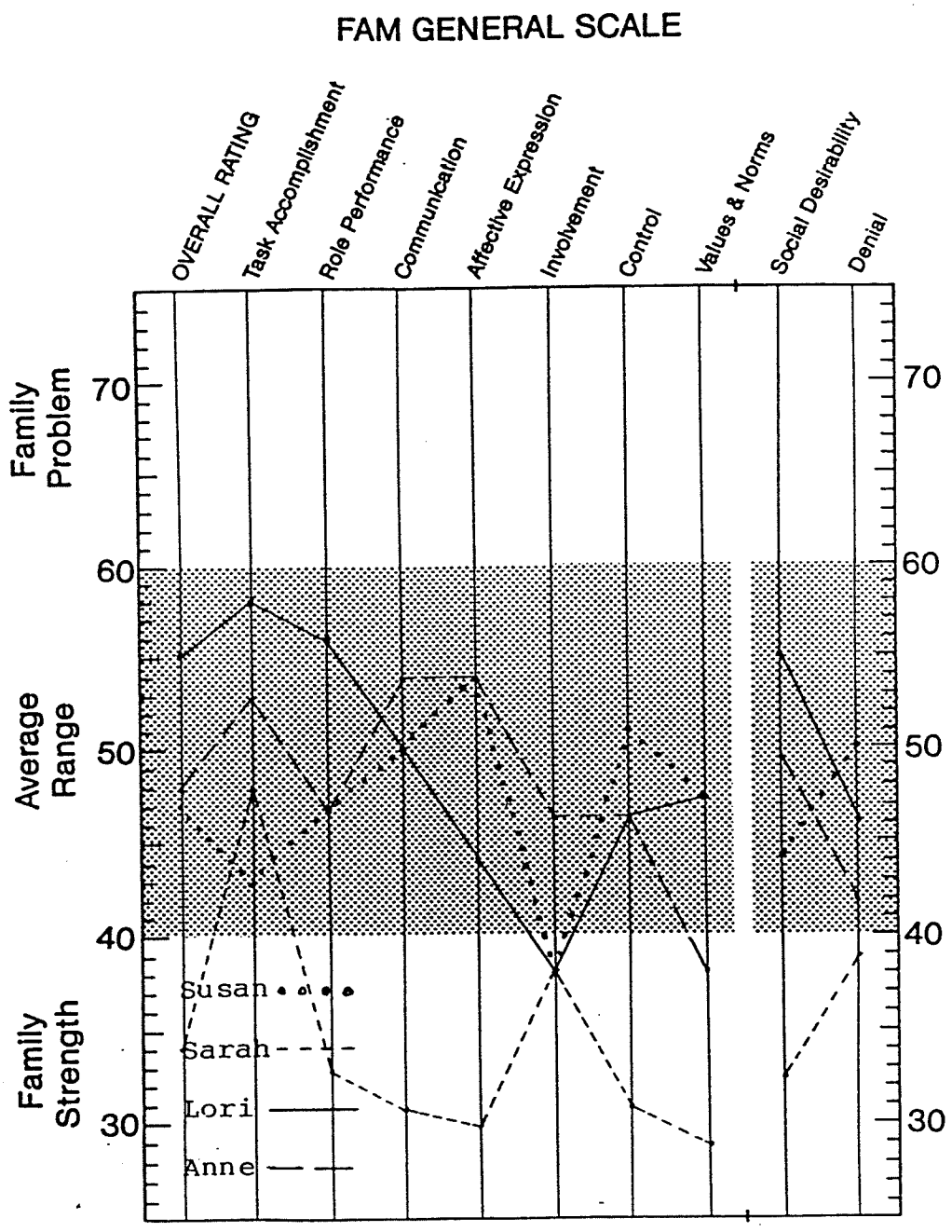


Figure 2

Family A: Post-test Profile Using FAM III General Scale



The self-anchored scale was administered at each session and showed similar improvements. On examination of individual session, rankings indicated that the bedside session with Jim had an impact on the ratings by the individuals. The bedside session with Jim was significant for family members, providing an opportunity for affective expression and validation of grief reactions. Role overload also decreased for Susan with Jim's death and Susan's role and tasks as a parent became clearer in relationship to her daughters. Individual sessions also proved significant, providing Sarah and Lori an opportunity for affective expression and disclosure. Overall, the self-anchored scale indicated the most marked improvement in the perception of family functioning for Susan and Sarah. However, all family members indicated a change in the positive direction over the course of therapy.

Therapist rating scale scores also indicated the perception that changes in the level of family functioning had occurred. However, the magnitude of the change was not as great as that perceived by the family. The resulting differences in therapist and client ratings

demonstrates the differences in perceptions held by the family and the therapist. According to Bloom and Fisher (1982), comparing the level of agreement between the therapist and the family member acts as a mechanism to ensure therapeutic goals fit with the client. De Shazer and colleagues (1986) also support this view. By acknowledging differences in therapist and client rating scale scores the therapist is directed to further explore constraints relevant to the complaint situation. From this perspective, comparing therapist and client ratings is a useful evaluative mechanism and provided direction in the therapeutic process. Tables 7 and 8 illustrate self-anchored and therapist rating scale scores.

In conclusion, this case illustrated the use of identifying an exception and utilizing the exception in order to promote the development of a solution. The first two sessions identified therapeutic goals and mechanisms for change. Subsequent sessions served to reinforce and amplify the changes already occurring.

TABLE 7

Family A: Client Self-Anchored Rating Scale Scores

Sessions	Susan	Sarah	Lori	Anne
1	5	-	-	-
2	7	-	6	7
3	7	2	6	7
4 - 7 (individual)	6	7	7	8
8	8	-	-	8

Note: Scale of 1-9 with higher numbers indicating improvement.

TABLE 8

Family A: Therapist Rating Scale Scores

Sessions	Susan	Sarah	Lori	Anne
1	5	-	-	-
2	6	-	6	5
3	6	5	5	5
4 - 7 (individual)	7	6	6	6
8	8	-	-	7

Note: Scale of 1-9 with higher numbers indicating improvement.

Case Example Two: Family E

The second case example will describe the solution oriented process, illustrating how the interventive strategy has been utilized and attempting to draw attention to situations where these strategies seemed less effective.

· Karen (71) and her family were referred by a nurse

on the Oncology Unit. The primary concern expressed by this nurse was how Karen's husband, John (73) coping in his role as caregiver. When approached by the nursing, John and Karen agreed to a Department of Social Work referral. The first meeting took place with the family in Karen's hospital room.

Assessment

Karen has been married almost fifty years to John. This couple retired from farming and live in a small town in rural Manitoba. John is a carpenter who used his skills to make their home wheelchair accessible. Karen was diagnosed with recurrent thyroid carcinoma and was admitted to St. Boniface General Hospital from a rural hospital following the collapse of one lung. The couple have two children, a son Steve (40) and a daughter Gwen (32). Steve runs the family farm and has never married. Gwen was born developmentally challenged. She lives with and is dependant upon her parents for support. John is the primary caregiver to Karen and provides care to Gwen. Both John and Karen describe their extended family as supportive, and these family members often visited Karen

in the hospital.

Part I: Client's Statement of the Problem

Karen was seen alone in the first session. Although brief, it provided an opportunity to begin to develop a rapport with the client. Karen was not feeling well and a time was arranged for the therapist to return.

During the second session, Karen and John were seen together. Both Karen and John contributed to the conversation, describing the events leading up to Karen's cancer diagnosis, her period of illness and, more recently, the events leading up to her admission to hospital. Karen expressed concern for her family and for her own health. John also showed his emotion. He spoke about his concern for Karen's health and appeared to be experiencing anxiety around the limited information about his wife's medical status.

Karen and John also talked about their children. They generally agreed that while their son, Steve, was coping adequately, their greatest concern was for Gwen.

Because Gwen missed the companionship of her mother, John brought her to visit her mother regularly. A number of other members of the extended family helped care for Gwen since her mother's illness. Karen seemed concerned about how Gwen would cope if she died, yet expressed confidence in the support available from John and other family members. In anticipation of their eventual death, John and Karen had planned ahead, making arrangements with a cousin to care for Gwen in the future.

The reason Karen gave for seeking therapy was that of uncertainty about her future. Karen was encouraged to elaborate on this problem. She further explained that there was a possibility she might not return home and would die in the hospital without ever seeing the farm and her home again. John's description of the presenting problem was similar. He was appreciative of the information and attention from medical and nursing staff, however was troubled with the thought that his spouse might not return home again.

Part II: Miracle Picture

John and Karen were asked the miracle question to facilitate the identification of goals for therapy. If a miracle happened tonight while you were asleep, what would you notice the next morning that was different? Karen said that she would be healthy and able to go home. She was encouraged to elaborate on the meaning of this "difference". Karen stated that she would go home even if it meant going home to die. John's response to the miracle question was similar. He stated that Karen would be well again so she could go home. Elaborating on this, John stated that the news the doctor would give them would be good.

It was apparent this couple had an accurate understanding of the seriousness of Karen's medical condition. Karen and John were asked if they knew whether alternatives existed for Karen besides staying in the hospital or recovering fully. Each responded that they had never asked this question. According to John, they did not feel it was their position to express their own wishes to the doctor. Karen's and John's world view

held physicians in high esteem. They believed it would be disrespectful to express their own opinions about wanting Karen to return home.

Karen and John were asked the scaling question in relationship to their goal of having Karen return home. However, this couple stated they could not answer this question because they felt the fate of Karen's health was in medical hands. This couple's perception of their situation and the decision not to express their own wishes placed them in a position of limited control over planning for Karen's future. Given their world view, the case became a challenge. The therapist had limited success in helping the couple elaborate on their "miracle picture" and in identifying small achievable goals.

Intervention

As the session progressed the presenting problem first identified by Karen and John was further defined as both an information and communication problem. This couple's belief about how they should behave in hospitals and with physicians left health care professionals

unaware of Karen and John's wishes. Adding to this, the family had no information about alternatives available to Karen, such as home care services, that might facilitate her returning home. At this point the therapist established an educational role. Intervention included providing information to the family, which lead the couple to examine their perceptions of the hospital system. During the third and fourth sessions, Karen and John asked for support to communicate their wishes for Karen to return home. Their case was discussed at the multi-disciplinary case conference and their wishes were relayed to the multi-disciplinary team. Further information on community resources was made available to Karen and John. Nursing staff arranged for Home Care to visit Karen.

Outcome

Intervention with this family included a total of four sessions over a two week period. Steve did not participate in therapy while Gwen was present for the third session. Gwen's participation was minimal and family members expressed being satisfied with this.

Karen's health stabilized and the physician recommended her discharged. This change in health status came unexpectedly and this couple ultimately accomplished their goals for therapy. The family was seen one more time for a short debriefing session approximately two weeks later.

In this case example the evaluation instruments supported the therapist's clinical observation of family functioning. In the pre test, family members scored between 47 and 55 on the overall rating scale. In general, scores on subscales tended to be moderate. Karen's rating in respect to values and norms are worth noting as her score illustrates the differences that exist between her world view and that of the larger system. A full list of the pre-test scores can be found in table 9. Post-test scores were not obtained. Figure 3 provides the pre-test FAM III profile.

The self-anchored scale was not administered because the family believed the scaling question had no relevance to the session. It would have been unethical to have insisted the family complete this scale. Consequently,

completion of the therapists rating scale was not possible.

In conclusion, this case illustrated the use of information and communication in order to promote the development of a solution. While the client goals were accomplished, finding exceptions and empowering the family system was a challenge, and advocacy became the primary role of this therapist.

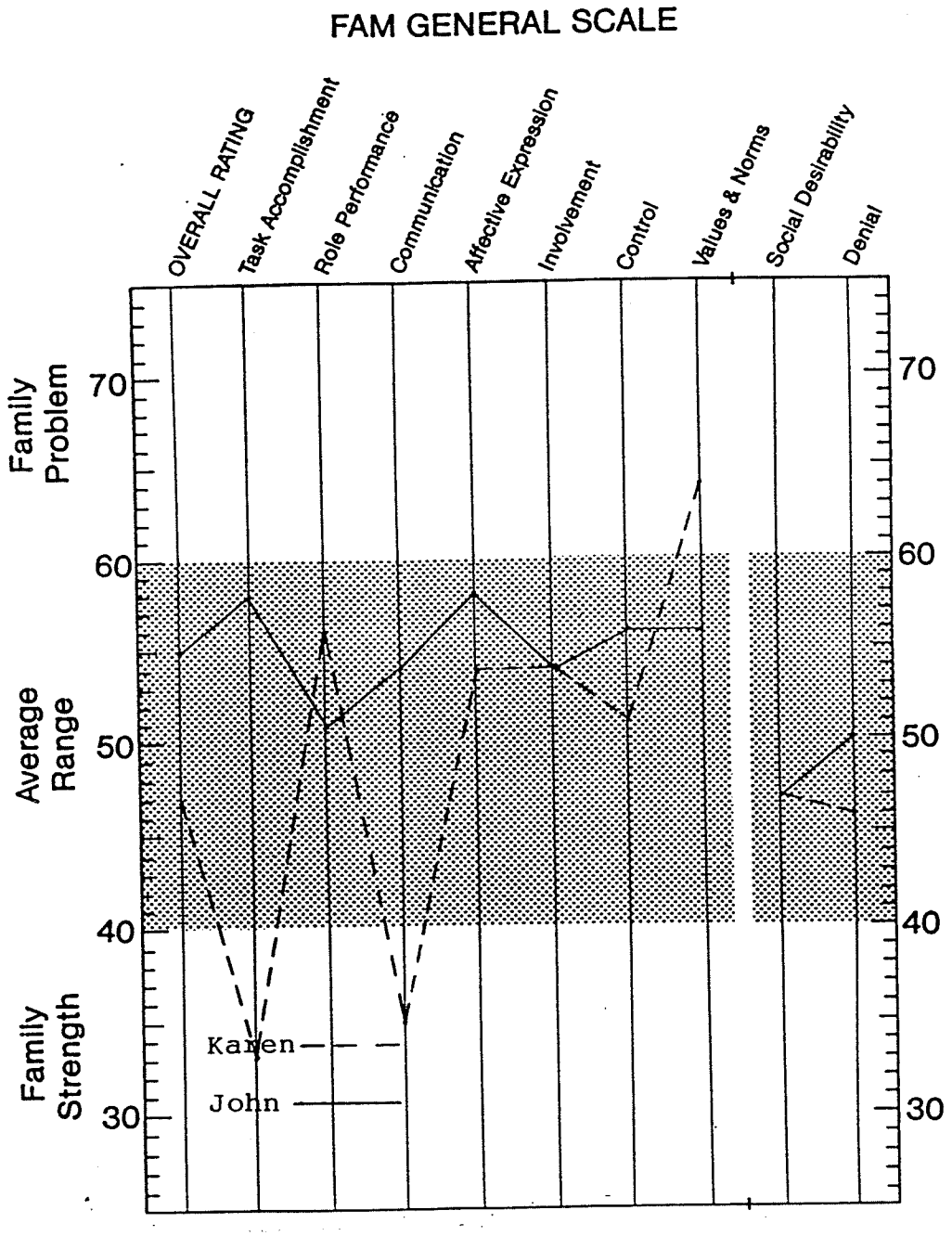
TABLE 9

Family E: Pre-test Results Using FAM III General Scale

Scale	Karen	John
Overall Rating	47	55
Denial	46	50
Social Desirability	47	47
Task Accomplishment	33	58
Role Performance	56	51
Communication	35	54
Affective Expression	54	58
Involvement	54	54
Control	51	56
Values and Norms	64	56

Figure 3

Family E: Pre-test Profile Using FAM III General Scale



CHAPTER FIVE

SUMMARY AND CONCLUSION

Evaluation of Practicum

This practicum provided family therapy services to six families over the course of three and a half months. Four of the families seen felt that they had accomplished and reached their goal. Four out of the six families were seen a total of four sessions. The lengthiest intervention was comprised of eight sessions, while the briefest involved only three sessions.

Overall, the practicum was a positive experience for the therapist and the families that were seen. The solution focused brief model of therapy was found to be effective for each of the families although components of this model were less effective with two of the families. Ongoing unresolved issues warranted that two cases be transferred to other social workers for continued therapy.

Solution focused brief therapy is effective in its ability to empower clients, which often promotes rapid change. Clients commented on having felt as though they had been understood. This feedback seemed to "fit" with

the information collected on the Client Satisfaction Questionnaire. Overall, this model of intervention is a respectful and valid method of therapy.

The situations that existed in cases where the writer felt "stuck" while using the model are worth discussion. Three reasons limited the effectiveness of therapeutic intervention during this practicum. These reasons included the overwhelming effects of an institutional setting for some clients, the likelihood of an ongoing crisis combined with inadequate social supports and, the therapist's limited level of skill in utilizing the model of practice.

In the illustration of the second case (Family E), the impact that an institutional setting, such as a hospital, can have upon a family system was underestimated. This family's world view served to disempower them from addressing the problem and accomplishing their goal. Information and communication became primary needs.

Another example (Family B) was a family where the 71

year old male patient was dying of prostate cancer and his spouse was having difficulty coping with the dying process. Inadequate social supports existed as all seven of their children lived in other parts of Canada. This is an example of a case that could not be concluded within as brief a period as others. Insufficient resources existed to appropriately support the spouse, creating a need for the family to remain connected to a therapist for reassurance that a support mechanism existed. While intervention had been successful in assisting this family to overcome their most immediate crisis, terminating involvement with the family would have been inappropriate. The nature of this case such that family members and health care professionals recognized and anticipated the likelihood of further crisis. From this perspective, therapeutic intervention can be understood as any number of brief interventions over a long period of time.

The last case example (Family D) involved a 67 year old male patient diagnosed with malignant melanoma (stage IV). Family members were having difficulty coping with his preoccupation with the disease and the possibility of

dying. Therapeutic intervention attempted to assist the patient and the spouse to identify and utilize personal strengths as a means of learning to cope with the emotional and social effects that the disease was having on the family system. The family found therapy helpful. However, after four sessions, the presenting problem was far from being resolved. Insufficient skills on the part of the therapist resulted in a lack of success in intervening with this family. In retrospect, the therapist was unable to communicate using a "language" relevant to the client system. The patient spoke in a language of stories and the writer had limited success in reframing therapeutic questions to fit within the context of the family's language.

In conclusion, identifying the client's future goals, discovering, amplifying and building exceptions allowed clients to begin to view their situation from a different perspective and created possibilities for change. The model allows a system to develop that includes the client and the therapist cooperating together to find solutions, and includes a process by which their progress can be monitored throughout the

course of therapy. Irrespective of the difficulties identified, an overall impression is that solution focused brief therapy is an empowering model.

Evaluation of Skill Development as a Therapist

Evaluating one's skill level as a therapist is a process of perceptions, previous experience and training. A number of areas were developed as a result of the practicum. The period of time spend at this practicum was reasonable to gain exposure to the solution focused brief therapy model and to intervene with the client population using prescribed therapeutic techniques. However, the span of the practicum was insufficient for detecting changes in the therapist's skill level with any level of confidence. One of the goals identified was to be evaluated on skill level by an external person. The Family Therapist's Rating scale was to be utilized for this task. However, duration of the practicum was not sufficient for this to be accomplished. In retrospect, extending the practicum to a period of six months would have allowed more time to accumulate clients, develop a level of comfort with the therapeutic model and collect

adequate audiotape materials for evaluation. However, the opportunity to develop conceptual understanding for a specific model combined with active practise helped to consolidate learning and provide the therapist with a new level of understanding.

Conclusions

Utilizing a solution focused approach calls into question the assumption that the problem (complaint) 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. The solution oriented model suggests that the relationship between the structure and the symptom can be considered circular as opposed to linear. For example, when a crisis occurs as a result of a cancer diagnosis, role and relationship changes occur as the family responds to the crisis and attempt to renegotiate homeostasis. This punctuation of the relationship between the problem (complaint) and the structure can have an effect on the understanding of the problem.

In a sense, this also emphasizes the tendency of solution focused brief therapy to be future focused. Concentrating on the present and future has the advantage of deflecting the seemingly natural desire to blame in favour of placing the onus for change on the client. At the same time, giving the client responsibility for change implies that the client has the power to make change happen and encourages him to search for exceptions which will reveal existing skills that can be utilized. Future focus also means that therapist biases and beliefs are less easily introduced into the identification of the problem. There is a strong urge, for example, to call family 'A' dysfunctional from the onset as a result of their dynamics a long time prior to Jim's illness. To do so opens the door to a pandora's box of 'psychopathology'. However, in reality, the family coped sufficiently prior to the crisis that Jim's changed role created. While there is no doubt that the family's history predisposed them to crisis, the therapist does not have the option of changing twenty years of behaviour. Nor, in fact, was there an invitation to do so since the family had never sought intervention in the past.

One of the assumptions of the solution focused approach is based on the constructivist idea that social reality is created (de Shazer, 1991). We select out information that does not fit with our perceptions. If a cancer patient's behaviour is seen as non-compliant, then various behaviours and responses occur and are understood within this context. However, if the perception changes to anxiety, a different understanding and response develops. The solution focus thus informs the therapist about how the client understands the problem and influences which solutions are considered. Restricting speculation regarding the cause of the problem, reduces the risk of ascribing the pathology to the family and/or family members. This is the purpose of cautioning the therapist to accept and place importance on only what is directly seen and heard from the client.

Many would argue that this view restricts a true understanding of the problem. However, de Shazer (1988) discusses how people often view their problems and 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 problem. He instead proposes that many solutions can be found within a 'both/and' conceptualization which allows for the inclusion of a greater amount of information. The expansion of this orientation promotes the development of an expanded world view and of subsequent solutions. In effect, one does not need to know what the problem is since identifying exceptions and what the solution will look like is sufficient (de Shazer, 1991).

Even when the therapist or client cannot describe what the client is complaining about, it is still possible for therapy to be effective. Problems that seem unmanageable to families, such as the overwhelming effects of a cancer diagnosis, may place family members in a position where they cannot recognize a solution for themselves. According to de Shazer et al (1986), sometimes all that is required is for the client to try something different since this may be enough to prompt the solution. It is common for clients to have no knowledge of what a solution to their problem would look like. If they did it is likely they would solve the problem on their own and never come to therapy. Using a

solution focus the therapist and client need only agree on when they will know the problem is solved. The intervention message is then developed to successfully fit the solution picture without full knowledge of the complaint.

Solutions to problems can be accomplished even if all family members are unable to attend therapy. According to de Shazer and colleagues (1986), change in one part of the system leads to change in the system as a whole. This systemic view, which is characteristic of a solution focus, proposes that the entire family can benefit from therapy even when members are absent. Therefore, it is not necessary for each family member to be present in therapy if this is an unrealistic expectation. This is important when considering the effects that cancer has on the family. Often members are unable to attend therapy if, in the patient's case, he is too ill or if other family members are overloaded with responsibility. From this perspective, using a solution focused approach is practical for existing problems experienced by a cancer diagnosis in a family.

De Shazer and colleagues (1986) also maintain that intervention should focus on promoting small changes as a mechanism that leads to further change and an improved situation. Goals that are too large increase stress on clients already in crisis. When goals are large it becomes difficult to establish a cooperative relationship and there becomes a greater chance the therapist and client will fail. For example, when a crisis occurs as a result of a cancer diagnosis the family's emotional resources are depleted as they attempt to renegotiate homeostasis. During this vulnerable state, large goals are likely to be unrealistic. In contrast, setting a small goal, which is the focus of the solution oriented model, communicates information to family members about their competence in finding solutions and resolving crisis.

In conclusion, the solution focused brief therapy model fits with crisis theory in relationship to a cancer diagnosis. This conceptual view, when considered in a situation such as when a family member is diagnosed with cancer, helps us to understand the effects of this disease, the emotional and social responses of the family

system, and the clues to empower family members to facilitate adaptation and homeostasis.

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APPENDICES

APPENDIX A

FAMILY ASSESSMENT MEASURE III

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 GENERAL SCALE

Date _____

Name _____

Age _____ years

Sex: M F

Your Family Position

1. ☐ Father/Husband
2. ☐ Mother/Wife
3. ☐ Child
4. ☐ Grandparent
5. ☐ Other,

Specify _____

a = strongly agree
b = agree
c = disagree
d = strongly disagree

1.	a b c d	11.	a b c d	21.	a b c d	31.	a b c d	41.	a b c d
2.	a b c d	12.	a b c d	22.	a b c d	32.	a b c d	42.	a b c d
3.	a b c d	13.	a b c d	23.	a b c d	33.	a b c d	43.	a b c d
4.	a b c d	14.	a b c d	24.	a b c d	34.	a b c d	44.	a b c d
5.	a b c d	15.	a b c d	25.	a b c d	35.	a b c d	45.	a b c d
6.	a b c d	16.	a b c d	26.	a b c d	36.	a b c d	46.	a b c d
7.	a b c d	17.	a b c d	27.	a b c d	37.	a b c d	47.	a b c d
8.	a b c d	18.	a b c d	28.	a b c d	38.	a b c d	48.	a b c d
9.	a b c d	19.	a b c d	29.	a b c d	39.	a b c d	49.	a b c d
10.	a b c d	20.	a b c d	30.	a b c d	40.	a b c d	50.	a b c d

TABLE FAM Interpretation Guide

1. TASK ACCOMPLISHMENT

LOW SCORES(40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
- basic tasks consistently met - flexibility and adaptability to change in development tasks - functional patterns of task accomplishment are maintained even under stress - task identification shared by family members, alternative solutions are explored and attempted	- 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	HIGH SCORES (60 and above) WEAKNESS
- 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	- 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	HIGH SCORES (60 and above) WEAKNESS
- 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	- 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	HIGH SCORES (60 and above) WEAKNESS
- affective communication characterized by expression of a full range of affect, when appropriate and with correct intensity	- 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	HIGH SCORES (60 and above) WEAKNESS
- emphatic involvement - family members' concern for each other leads to fulfilment of emotional needs (security) and promotes autonomous functioning - quality of involvement is nurturant and supportive	- 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	HIGH SCORES (60 and above) WEAKNESS
- 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	- 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	HIGH SCORES (60 and above) WEAKNESS
- 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	- 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 sated rules are subverted by implicit rules - degree and latitude is inappropriate

APPENDIX B

SELF-ANCHORED AND THERAPIST RATING SCALES

SELF-ANCHORED SCALE

GOAL: _____

Rate yourself in terms of how close you are to achieving this goal

9	8	7	6	5	4	3	2	1
Have not started			Needs much more work		Close to achievement			Goal has been achieved

Date of Session: _____

Name: _____

THERAPIST RATING SCALE

GOAL: _____

Rate yourself in terms of how close you are to achieving this goal

9	8	7	6	5	4	3	2	1
Have not started			Needs much more work		Close to achievement			Goal has been achieved

Date of Session: _____

Name: _____

APPENDIX C

CLIENT SATISFACTION QUESTIONNAIRE AND LETTER

Hôpital général St-Boniface General Hospital

Dear:

You will recall that I met with you and/or your family recently. Attached is a short questionnaire asking for feedback from individuals and families who have been recipients of social work services from myself during my practicum.

Please complete the questionnaire and return it in the self-addressed envelope. Your feedback is very important and is useful to help me better understand the needs of families living with cancer.

Sincerely,

Heather Neilson-Clayton H.B.S.W., C.S.W.
M.S.W. Student Social Worker

409 Taché, Winnipeg, Manitoba, Canada R2H 2A6
Tel (204) 233-8563 Fax (204) 231-0640

CLIENT CODE: _____

THE CLIENT SATISFACTION QUESTIONNAIRE (CSQ)

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

IRCLE YOUR ANSWER

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

4	3	2	1
Excellent	Good	Fair	Poor

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

4	3	2	1
No, definitely not	No, not really	Yes, Generally	Yes, Definitely

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

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

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

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

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

4	3	2	1
Quite Dissatisfied	Indifferent or mildly Dissatisfied	Mostly Satisfied	Very Satisfied

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

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

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

4	3	2	1
Very Satisfied	Mostly Satisfied	Indifferent or mildly dissatisfied	Quite Dissatisfied

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

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

---

ADDITIONAL COMMENTS:

APPENDIX D

FAMILY THERAPIST RATING SCALE

APPENDIX A

THE FAMILY THERAPIST RATING SCALE (FTR)

Family Therapist Rating Scale

Directions: Rate the relative effectiveness with which the family therapist engages in the behaviors listed below. Some of these behaviors may be associated with a school of therapy other than your own. Try to be neutral and rate the relative effectiveness with which the therapist performs each behavior regardless of whether you agree or disagree with the type of intervention. In other words, try not to rate the model of therapy, just the behavior as identified by the statement on the rating scale.

Not Present (0); Ineffective (1); Neutral (2); Minimally Effective (3); Effective (4); Very Effective (5); Maximally Effective (6)

0 1 2 3 4 5 6

Structuring Behaviors

1. ___:___:___:___:___:___:___: Helps the family define their needs.
2. ___:___:___:___:___:___:___: Stops chaotic interchanges.
3. ___:___:___:___:___:___:___: Shifts approach when one way of gathering information is not working.
4. ___:___:___:___:___:___:___: Uses short, specific and clear communications.
5. ___:___:___:___:___:___:___: Asks open ended questions.
6. ___:___:___:___:___:___:___: Helps clients rephrase "why" questions into statements.
7. ___:___:___:___:___:___:___: Makes a brief introductory statement about the purpose of the interview.
8. ___:___:___:___:___:___:___: Lays down ground rules for the therapeutic process.
9. ___:___:___:___:___:___:___: Clarifies own and client's expectations of therapy.
10. ___:___:___:___:___:___:___: Explicitly structures or directs interaction among family members.

Relationship Behaviors

1. ___:___:___:___:___:___:___: Engenders hope.
2. ___:___:___:___:___:___:___: Uses self-disclosure.
3. ___:___:___:___:___:___:___: Demonstrates warmth.
4. ___:___:___:___:___:___:___: "Communicates" the attitude that the client's problem is of real importance.
5. ___:___:___:___:___:___:___: Tone of voice conveys sensitivity to the client's feelings.
6. ___:___:___:___:___:___:___: Speaks at a comfortable pace.
7. ___:___:___:___:___:___:___: Empathizes with family members.

APPENDIX A

THE FAMILY THERAPIST RATING SCALE -continued

8. ___:___:___:___:___:___:___: Confirms family members' experience of an event.

9. ___:___:___:___:___:___:___: Attempts to improve the self-esteem of individual family members.

10. ___:___:___:___:___:___:___: Demonstrates a good sense of humor.

Historical Behaviors

1. ___:___:___:___:___:___:___: Directly asks about the current relationship between a spouse and his/her parents and siblings.

2. ___:___:___:___:___:___:___: Explores the couple's mate selection process.

3. ___:___:___:___:___:___:___: Emphasizes cognitions.

4. ___:___:___:___:___:___:___: Assembles a detailed family history.

5. ___:___:___:___:___:___:___: Avoids becoming triangulated by the family.

6. ___:___:___:___:___:___:___: Attempts to help clients directly deal with parents and adult siblings about previously avoided issues.

7. ___:___:___:___:___:___:___: Assigns or suggests that family members visit extended family members.

8. ___:___:___:___:___:___:___: Maintains an objective stance.

9. ___:___:___:___:___:___:___: Makes interpretations.

10. ___:___:___:___:___:___:___: Collects detailed information about the etiology of the identified problem.

Structural/Process Behaviors

1. ___:___:___:___:___:___:___: Checks out pronouns to see who did what to whom.

2. ___:___:___:___:___:___:___: Assigns tasks both within the session and outside it.

3. ___:___:___:___:___:___:___: Concentrates on the interaction of the system rather than the intrapsychic dynamics.

4. ___:___:___:___:___:___:___: Employs paradoxical intention.

5. ___:___:___:___:___:___:___: Relabels family symptoms.

6. ___:___:___:___:___:___:___: Reorders behavioral sequences (e.g., order of speaking, who speaks to whom).

7. ___:___:___:___:___:___:___: Rearranges the physical seating of family members.

8. ___:___:___:___:___:___:___: Helps the family establish appropriate boundaries.

9. ___:___:___:___:___:___:___: Elicits covert family conflicts, alliances and coalitions.

APPENDIX A

THE FAMILY THERAPIST RATING SCALE- continued

10. ___: ___: ___: ___: ___: ___: ___: Assumes the role of expert technician who observes and then intervenes.

Experiential Behaviors

1. ___: ___: ___: ___: ___: ___: ___: Uses family sculpting.
2. ___: ___: ___: ___: ___: ___: ___: Encourages family members to find their own solutions.
3. ___: ___: ___: ___: ___: ___: ___: Encourages individuals to share their fantasies.
4. ___: ___: ___: ___: ___: ___: ___: Asks for current feelings.
5. ___: ___: ___: ___: ___: ___: ___: Lets the clients choose the subject of the session.
6. ___: ___: ___: ___: ___: ___: ___: Attempts to focus on process rather than content.
7. ___: ___: ___: ___: ___: ___: ___: Uses role playing.
8. ___: ___: ___: ___: ___: ___: ___: Responds to his/her own discomfort.
9. ___: ___: ___: ___: ___: ___: ___: Uses own affect to elicit affect in family members.
10. ___: ___: ___: ___: ___: ___: ___: Keeps the interaction in the here and now.

Figure 1. THE FAMILY THERAPIST RATING SCALE PROFILE

Family Therapist Rating Scale Profile

Therapist's Name _____ Comments _____

Date _____

Rater _____

Mean Rating of Behaviors Observed	Raw Score	Structuring	Relationship	Historical	Structural/ Process	Experiential
6	60	-	-	-	-	-
	55	-	-	-	-	-
5	50	-	-	-	-	-
	45	-	-	-	-	-
4	40	-	-	-	-	-
	35	-	-	-	-	-
3	30	-	-	-	-	-
	25	-	-	-	-	-
2	20	-	-	-	-	-
	15	-	-	-	-	-
1	10	-	-	-	-	-
	5	-	-	-	-	-

Note: A profile of a family therapist's behavior may be constructed in two ways. In one approach, raw scores, the total points within each category, may be added and placed on the profile. However, it may at times be helpful to use the mean ratings of only those behaviors actually observed within each category. The above profile has been constructed to accommodate either method.

APPENDIX E

CONSENT FOR AUDIO RECORDING

Hôpital général St-Boniface General Hospital

CONSENT FOR AUDIO AND/OR AUDIO-VISUAL RECORDING

I (we)_____ do hereby consent to:

1. the recording on audio or audio-video tape(s) individual, marital, family or group sessions.

2. the limited use of these tape(s) for professional supervision only.

I further understand that:

1. these tapes will only be retained so long as I am receiving services from the Department of Social Work at St. Boniface General Hospital.

2. these tapes will be held until not later than September 1st, 1993 at which time they will be destroyed.

3. any other use of these tapes requires my further written consent.

4. these tapes are the property of the Department of Social Work at St. Boniface General Hospital.

5. access to services of the Department of Social Work are not dependent on my signing of this consent.

6. I may at any time revoke this consent by so indicating in writing and that such will not in any way limit my access to services of the Department of Social Work.

Dated at_____ this_____ day of_____

A.D., 19____

_____
Signature

_____
Signature

_____
Witness

409 Taché, Winnipeg, Manitoba, Canada R2H 2A6
Tel (204) 233-8563 Fax (204) 231-0640