STRUCTURAL AND BRIEF SOLUTION FOCUSED THERAPIES WITH FAMILIES EXPERIENCING PARENT-ADOLESCENT CONFLICT

BY
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A practicum presented to the
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in partial fulfillment of the requirements
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ABSTRACT

The purpose of this practicum was twofold: 1) to familiarize and increase the competence and confidence of a beginning therapist in each of the Structural and Brief Solution Focused therapies and; 2) to investigate the efficacy of each model, as utilized by a beginning therapist, in intervening with parent-adolescent conflict.

A Structural Family Therapy (SFT) model or Brief Solution Focused Therapy (BSFT) model was applied to families experiencing parent-adolescent conflict who requested service from Kinark Child and Family Services in Peterborough, Ontario. In addition, in one case a combined SFT and BSFT approach was used. Family members reported a variety of concerns about their adolescent members at referral including drug use and related charges, parent-teen conflict, behaviour problems, and, violence and aggression towards parents. Detailed case studies describe the SFT and BSFT hypotheses used in therapy and the specific interventions which were employed with three families. Therapeutic efforts were evaluated using client and therapist reports and the General Scale of the Family Assessment Measure (FAM). Evaluation measures suggest that both of the therapeutic methods utilized demonstrated effectiveness for families served. One exception, occurred in the case of the "B" family where the FAM scores

for the teenager became more distressed although her parents saw the family as being stronger. Case descriptions and FAM profiles are offered for each of the families treated and the implications of SFT and BSFT for treatment of families with adolescents are considered.

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I would also like to thank Mr. John Britton for having the courage and energy to take on a student placement complete with all of the additional supervisions, orientation and support needed, in a work place that already doesn't have enough hours in the day.

Finally, I would like to thank my husband, Marc, who supported me emotionally, financially, and even physically at times (during the final crunch!) in order to help me achieve the goal I had set out for myself years ago. His humour, patience, and motivational "speeches" helped me through the more trying times completing this degree in another (cold!) province.

Finally, a special mention to our son, Jacob Marcus, who literally chose to announce his impending arrival as I was typing the conclusion chapter of this report - and was born on June 17, 1997.

CHAPTER 1: INTRODUCTION

Purpose and Learning Objectives:

The purpose of this practicum was to give me an opportunity to work with both the Structural Family Therapy (SFT) and Brief Solution Focused Family Therapy (BSFT) with families experiencing parent-adolescent conflict. The learning objectives were as follows:

1) to develop a thorough knowledge of Structural Family Therapy and Solution Focused Brief Therapy;

2) to acquire skill in using these frameworks as methods of intervening with families experiencing parent-teen conflict;

3) to increase my confidence in assuming the role of therapist;

4) to ensure the completion of the MSW practicum requirements.

Background

I chose this topic for a variety of reasons. Firstly, I felt that my greatest area of clinical training need, in terms of further study and practical experience, was in working with families. Up to this point, I had developed a broad range of experience in working with children and families in such settings as School Boards and Children's Mental Health Centres as a Behaviourist and as a Child and Youth Worker. However, my past direct social work positions were held in Child Welfare Services where the emphasis of intervention was often limited by the mandate and time, and in the Ministry of Education, where the emphasis was more on individual counselling. Wanting to work more effectively with families, and hoping to work in a children's mental health centre upon completion of this degree, I chose to investigate the efficacy of both SFT and BSFT. I chose the SFT model because it provides the beginning therapist with a foundation for viewing, understanding and intervening with families, and I chose the BSFT model because many mental health (and other) centres are moving to a managed care approach involving fewer available counselling sessions with clients. Finally, I chose the parent-teen conflict population in order to improve skills that will likely be universally helpful with any families with teens, regardless of presenting issues.

Overview of Practicum

This report will investigate parent-adolescent conflict in the context of family development and the developmental tasks of adolescence. An overview of conflict theory and conflict resolution, as well as a specific look at the impact and resolution of conflict with adolescents will also be investigated. A description of both SFT and BSFT will be presented followed by case studies depicting the use of these approaches independently and combined. Attainment of my learning goals will then be discussed.

CHAPTER 2: ADOLESCENCE, CONFLICT AND THE FAMILY LIFE CYCLE

Family Development

According to Minuchin (1974) the family is a social unit that faces a series of developmental tasks which, although cultural differences may exist, have universal roots. At each developmental stage there are a number of tasks that need to be addressed in order to maintain continuity in the family system. Minuchin argues that at different periods of development the family must adapt and restructure by continually accommodating and changing patterned transactions. He identifies the first stage of family development as beginning with marriage. Some of the tasks that face the couple include developing a mutual accommodation for small routines. The next phase is marked by the birth of a child and this, according to Minuchin, creates radical change in the family organization including new subsystems, physical and emotional commitment to the child, and a change in transactional patterns. In the next phase children enter adolescence and new siblings may join the family. In the final phase of family development the children leave the family and the original unit of husband and wife are left but under very

different circumstances. In regards to the developmental challenges that families encounter Minuchin stated:

> The family must meet the challenge of both internal and external change while maintaining its continuity, and must support and encourage all its members' growth while adapting to a society in transition. These tasks are not easy. (p. 18)

Minuchin maintains that adolescence is a particularly difficult time for the family in that as the child matures the demands made by parents begin to conflict with the adolescent's need for age-appropriate autonomy. At this stage parenting becomes a difficult process of mutual accommodation as rules are contested and adolescents make new demands on parents for more time and emotional commitment.

Carter and McGoldrick (1989) take a three-generational view of the transformation of the family unit in adolescence. As with Minuchin (1974), Carter and McGoldrick maintain that structural shifts and renegotiation of roles in families are essential during adolescence. However, they propose that the intensity of adolescent demands often create shifts in relationships across several generations causing stress both up and down the generations. These authors maintain that "flexibility is the key to success for families at this stage" (p. 257) but that many parents and adolescents face typical fears or "blocks" (p. 258) that hinder the adolescent's need for greater independence and developmental growth: sexuality; - transformation of the

physical self; identity - transformation of the self, and; autonomy - transformation of decision making.

Developmental Tasks of Adolescence

Erikson's (1968) model of human development proports that the principal developmental task facing adolescents is to establish an independent personal identity. His model describes the emotional development of the adolescent in transition to adulthood and generally stresses autonomy and intimacy. According to the model, this new identity must combine the adolescent's current and past self-images with the image of the roles they are expected to assume as adults. The key challenge for adolescents at this stage of development is to resolve the "identity crisis". If this stage of development is successfully attained the adolescent will emerge with a strong positive sense of an independent self. If this stage is not successfully attained the adolescent will instead develop a diffuse or negative identity. Erikson stressed the importance of the adolescent establishing emotional and physical intimacy with a partner and described the achievement of this in young adulthood as a stage of intimacy versus isolation. During this stage, according to Erikson, the primary developmental challenge is for young people to commit

themselves to "enduring relationships with others in love, work and friendship or risk being isolated and alone". In each of Erikson's stages of development, one must successfully work through related tasks in order to be prepared to meet the challenge of the next stage. Successful resolution of the adolescent stage prepares them for adequate psychosocial adjustment of the emerging adult.

Stern, Van Slyck, and Newland (1992) stated that adolescence is a period of transition that involves biological, cognitive, social and cultural boundaries. They divide adolescence into three distinct substages: early adolescence (ages 11-13), middle adolescence (ages 14-16) and late adolescence (ages 17-22). They state that the key developmental task in early adolescence is to form a unique identity as part of the move toward independence from parents. They highlight the body changes that can be dramatic in this stage and describe the cognitive thinking of early adolescents as concrete and egocentric. Socially, this stage is characterized by an over reliance on same-sex peers and great pressure to conform to peer-group standards as they make social comparisons to gauge whether their own development is normal. This stage is often marked by rebellious and conflictual behaviour as adolescents at this stage are attempting to de-emphasize emotional ties with parents. Stern et al. conclude that early adolescence is characterized by concerns about body image, unrealistic plans for the future, concrete thinking, same sex peer group, and the active but

ambivalent struggle for independence. They described middle adolescence as being characterized by the task of developing an integrated sexual identity - a masculine or feminine self-concept. Adolescents at this stage are still quite self-centered about their body image but less so with their physical changes. At this stage they have developed a greater ability to think in the abstract and are capable of increased introspection, although generally their thinking and value systems remain self-centered and narcissistic and maintain a sense of invulnerability and lack of reality testing that interferes with more mature and productive thought processes. Stern et al. state that adolescents' perceived invulnerabilty is often a primary source of conflict in many families. They describe the late substage of adolescence as a period involving the developmental task of planning a future career and taking on an identity as a functional and responsible adult. They suggest that a realistic body image, cognitive growth, an ability to think abstractly and to think through problems and develop alternatives is generally at full development at this stage. However, they proport that this substage is also characterized by high idealism and rigid concepts of right and wrong, as well as a resolution of the independence and autonomy issues from past substages. In addition, there is an emphasis on the development of intimate relationships. Stern et al. state that the two characteristics of establishing serious relationships and automous behaviour can contribute to much of the conflict between adolescents and their parents at this substage. They

conclude that adolescence can be considered a period involving change on a number of dimensions including physical and sexual status, formation of a personal identity, financial and psychological independence from parents, mature sexual relationships and career plan and definition. They identify the psychological and social crises and stresses that are typical of this stage as individual (e.g., body and self-image issues), family (e.g., conflict with parents) and extended social network (peer, academic, etc.).

Pittman (1987) described adolescence as " a period of normal psychosis" and that the task for the adolescent is to "survive another day by arranging sufficient emotional support from peers, or whomever else can soothe the stings of social humiliation" (p. 176).

Overview of Conflict Theory

Collins and Laursen (1992) define conflict as oppositional interactions. Similarly, Deutsch (1973) defines conflict as "incompatible activities" that occur within a person, group or nation or between two or more people, groups or nations (interpersonal, intergroup, international). Deutsch goes on to identify six types of conflict: 1) veridical conflict - is objective and perceived accurately; 2) contingent conflict - conflict that could disappear if alternate solutions were recognized; 3) displaced conflict - the parties in conflict are arguing about something not directly related to the primary issue; 4) misattributed conflict - the conflict is between the wrong parties and usually over the wrong issues; 5) latent conflict - a conflict should be occurring but is not due to repression, displacement or misattribution, and; 6) false conflict - conflict without an objective basis usually due to misperception or misunderstanding. These forms of conflict may exist simultaneously or may transform from one to another during the conflict (Deutsch, 1973).

Deutsch (1973) also identified five basic types of issues involved in conflict: 1) control over resources; 2) preferences and nuisances - the tastes of one person or group impinge on others; 3) values; 4) beliefs, and; 5) the nature of the relationship between parties - regarding views and desires in their relationship.

Conflict can be either constructive or destructive (Deutsch, 1973). In destructive conflicts participants are dissatisfied with the results and feel they have lost as a result of the conflict. In constructive conflict participants feel satisfied with their outcomes and feel that they have been productive because of the conflict. Deutsch also points out that conflict has many positive functions:

> It prevents stagnation, it stimulates interest and curiosity, it is the medium through which problems can be acquired and solutions arrived at, it is the root of personal and social change. Conflict is often part of the process of testing and assessing oneself and, as such, may be highly enjoyable as one experiences the pleasure of the full and active use of one's capacities. In addition, conflict demarcates groups from one another and thus helps establish group and personal identities; external conflict often fosters internal cohesiveness. (p. 9).

Resolution of Conflict

Vuchinich (1987) offers the following commonly used strategies for conflict resolution: 1) submission - where one person accedes to the demands of the other; 2) compromise - concessions are made by both parties; 3) third party intervention - where both parties accept a solution proposed by a previously uninvolved person; 4) stand-off - a shift in topic of speech or focus of activity, and; 5) withdrawal - one person refuses to continue the exchange. The stand-off and withdrawal approaches are often referred to as disengagement. Vuchinich found that half or more of all conflicts involving adolescents are resolved by stand-off or withdrawal, fewer still are resolved by unilateral power assertion, and the least amount are solved by negotiation. Montemayor and Hanson (1985; as cited in Collins & Laursen, 1992) indicate that adolescents' conflicts are most frequently solved through power assertion and disengagement.

Adolescents, Their Families and Conflict

As Collins and Laursen (1992) stated - "adolescence" and "conflict" have been considered virtually synonymous terms both in formal theory and in popular stereotypes. There are many different theories regarding the increase in conflict during adolescence. Psychoanalytic theory identifies hormone development as significant, while biopsychosocial approaches attribute "heightened perturbations to violations of expectations and accumulation of stressors associated with multiple personal and social transitions" (Collins & Laursen, 1992). Still other views suggest that the chance of conflict increases as adolescents develop cognitive competence which allows them to recognize inconsistencies and imperfections in others (Collins & Laursen, 1992). Carlton-Ford and Collins (1988; as cited in Collins and Laursen, 1992) suggest that the most commonly reported conflict issues between parents and teens involve authority, autonomy, and responsibilities.

Barber (1994) stated that consistent with past research, conflict occurs primarily over everyday matters such as chores and dress rather than over substantive issues such as sex and drugs. However, he qualifies these findings by stating that issues such as sex and drugs may not be discussed as frequently as everyday events.

Impact of Parent-Adolescent Conflict

Shagle and Barber (1993) found that family, marital and parent-child conflict can lead to feelings of self derogation and suicidal ideation in many adolescents. Tomlinson (1991) maintains that the effect of unacceptable behaviour and the struggle for control has a most dramatic effect on parents, children and the family as a whole. According to Tomlinson, parents report many of the following during parent-adolescent conflict: serious grief reaction due to the loss of the dream they have for their child and their own failure to do anything about it; high stress associated with their reaction to unacceptable behaviour and their need to cope with control struggles, and; social isolation as a result of their shame regarding their teen's behaviour and from being made to feel responsible for their teen's behaviour by friends, relatives and agencies in society (school, police, etc.). Tomlinson further stated that parents often become more reactive in highly charged situations involving adolescent defiance. In addition, parents tend to become personally disorganized, fatigued, overwhelmed by a sense of personal failure, lonely and isolated and defensive about power and control. In addition, the marriage is often affected so that parents are often unable to provide basic supports to each other and can become mired in spousal conflict and spousal blaming and can be pulled in to parent-adolescent coalitions against the other parent. To sum, it appears as though, according

to Tomlinson, parent-adolescent conflict tends to increase if adequate intervention and support is not available.

Carter and McGoldrick (1989) emphasize a three-generational method of assessing families experiencing conflict with their adolescents. They stress the importance of tracking relationship patterns across generations in order to connect present conflicts to past unresolved family conflicts. They proposed that this allows family members to be more objective about their interactions with each other. The role of the therapist is to help the different generations "accommodate to the life cycle transitions simultaneously ... events at one level have a powerful effect on relationships at each other level" (Carter & McGoldrick, 1989). It is also the role of the therapist to help family members view the future in a less dangerous way.

Carter and McGoldrick (1989) suggest several aspects of clinical intervention with adolescents and their family members, including: 1) reframing the family's conceptions of time; 2) working with subsystems and other relatives - parents, adolescents, siblings, aunts and uncles, etc.; 3) use of rituals; and 4) use of self.

The goal of reframing the family's conceptions of time is to "free the system from the situation in which time has stopped. Tracking the system in relation to different time spheres helps identify the points in the life cycle at which the family appears stuck" (p. 271). They suggest that when families

first come to therapy they are stuck and frightened and are experiencing the present as endless and the future as being threatening or dangerous. These authors go on to suggest that the therapist use questions focused on eliciting differences between family relationships at the time of symptom onset and at earlier times in the family's history in order to emphasize the process of change in a family who feels that time has stopped. In addition, Carter and McGoldrick maintain that the idea of future change can be introduced to the family by offering them new connections between the present and the past and by encouraging them towards new options. They suggest that meeting with subsystems and other family members can often elicit information that would not otherwise be released thereby introducing the system to new possibilities.

Working with family subsystems is " a powerful intervention for restructuring and redefining relationships when families with adolescents become developmentally stuck" (Carter & McGoldrick, 1989, p. 272). They suggest that the therapist first meet with the entire family in order to assess patterns and then meet with parents and adolescents separately. Meeting separately with subsystems is beneficial to the therapist in that it increases their ability to support both generations at once while clarifying boundaries, and helps one to avoid being caught in power struggles. The authors state that the therapeutic goal for meeting separately with the parents is to create a safer atmosphere where "they can feel freer to be more objective about

their role as parents, and to explore struggles they may have in other areas of their lives, such as marriage, work, being single or divorced, or problems with their families of origin" (p. 274). Carter and McGoldrick explain that individual meetings with adolescents gives the therapist the opportunity to assess their functioning outside their family system where they may feel freer to express their opinions and feelings, as well as fears and secrets. The therapist should use questions to address values and beliefs about life, love, sex, responsibility, education, drugs, friends, family, and the future, in order to clarify the adolescent's concept of self, or identity. Focusing on how these ideas are similar or different from parental views may help the therapist identify areas of conflict with parents that need to be unblocked. It is important to meet with siblings because they are affected by the changes made in the system which accommodates the adolescents. The therapeutic goal here is to foster support between the siblings and to foster their developmental growth by asking them to take risks with their parents and peers. Meeting other relatives can make it easier to identify generational patterns that may be affecting the family system in the present.

Rituals play an important role in our society however, our society lacks rites to celebrate/mark the move from adolescence into adulthood. Carter and McGoldrick (1989) maintain that prescribing rituals to families with adolescents can have a therapeutic effect in that they may reduce anxiety about change by offering stability, as well as promoting traditions or

creativity for making the transition from adolescence to adulthood. The authors suggest that families stuck in transitions are provided with the opportunity to mark growth toward maturity by celebrating such events as 16th birthdays, graduations, completions of drivers licenses, etc.

Finally, Carter and McGoldrick (1989) emphasize the use of self in engaging families with adolescents in therapy. They stress that the therapist must feel free to join, support, or confront either generation when necessary. The authors point out that this is very difficult as it is often natural for one to side with either the parents or adolescent and thereby view the other as a victim. Carter and McGoldrick stated that it is important for the therapist to ask questions of themselves regarding their own experience as an adolescent in order to become more aware of personal issues that may interfere with effective intervention.

Pittman (1987) emphasized the role of the parents in the family and stated that this is where adolescents must derive their stability. He further stated that one of the main goals of the parent should be to provide expertise on "matters of substance" to their adolescent. In particular he stressed morality and sexual morality while suggesting that battles over adolescent styles were not worthwhile. He also stressed that parents attempt to view their need to intervene with adolescents as " a series of hurdles along the track to adulthood" while keeping in mind the temporary nature of adolescent conflict instead of viewing them as permanent character flaws. This is

similar to Carter and McGoldrick's suggestion that reframing the family's conception of time is useful.

Similarly, Grace, Kelley, and McCain (1993) found that self-reported conflict was positively correlated with mothers' and teenagers' beliefs that one another's negative behaviour was intentional, selfishly motivated, and blameworthy.

In addition, Finchman (1985; as cited in Grace et al., 1993) stated that, "perceiving negative behaviour as determined by pervasive characteristics promotes conflict in other relationship domains and may lead to generalization of anger across conflict situations".

Compernolle (1981) stressed the importance and effectiveness of firstly re-establishing "adequate joint parental authority". He defined "joint authority" as a basic agreement between parents about child rearing issues (such as what they want and how it will be implemented) and "adequate" as a balance of control and autonomy that is age appropriate. Compernolle argued that adequate leadership is a necessary condition for the development of the child's autonomy and self confidence. It limits potential conflict by lessening parental division and by not diverting conflict before it is resolved (Minuchin, 1974). Compernolle maintained that adolescence is the crucial time when the autonomy of the child becomes more important than parental control. Consequently, problems tend to arise when the control by the parents is inadequate for the developmental stage of the child. He further

stated that the restoration of clear, consistent, and unanimous rules and limits (delivered with age appropriate flexibility) can "cure" symptoms such as depression in adolescence.

Many behavioural researchers have found that there is a link between problem solving deficits, poor communication skills, and high levels of parent-adolescent conflict (e.g., Prinz, Foster, Kent & O'Leary, 1979; Robin & Canter, 1984; Robin & Weiss, 1980).

Sternberg and Bry (1994) investigated the impact of the therapist intervention of increasing family members' range of suggestions of solutions to family problems. They found that family members were more likely to suggest ideas to solve their problems when their suggestions of solutions were directly acknowledged by the therapist. They also found that reported conflict decreased in two of three families studied when this particular technique was used by the therapist.

Tomlinson (1991) suggested that practitioners should keep a positive perception of parents so that they can be defined as concerned rather than incompetent, abusive or neglectful. He also suggests that interventions should be done first with parents, since it is usually they who seek help in the first place and are the most eager to commit to a helping process. He stated that treatment should initially be directed toward their feelings and concerns, and to the level of effect that the conflict is having on them, in order to restore them to a level of leadership in the family.

Styles of Parental Authority

Hopkins (1983) identified three styles of parental authority: permissive parents, who allow adolescents almost unlimited freedom to make their own decisions without parental constraint; democratic parents who utilize group discussion of issues and problems and group decisions about plans of action; and autocratic parents who tell their children what to do. He stated that adolescents raised by permissive parents tend to demonstrate the most autonomy particularly when some discipline is combined with explanation. Adolescents with democratic parents tend to be compliant and adolescents with autocratic parents tend to have limited autonomy and room for independent thinking. Consequently, it appears as though an authoritarian family style limits an adolescent's ability to appropriately achieve the developmental goal of autonomy. Hopkins (1983) further stated that a curvilinear relationship exists between parental restrictiveness and adolescent rebellion: parents who are either highly restrictive or highly permissive are more likely to have rebellious adolescents (Balswick & Macrides, 1975; Kandel & Less, 1972; as cited in Hopkins, 1983)

Similarly, Patterson (1995; as cited in Fraser, 1996) stated that a common parenting pattern in homes where children are aggressive and defiant is for parents to either give in or respond with disproportional force to demands or conflict. In this sense, Fraser (1996) argued that aggressive behaviour becomes rewarding for the children and increases their likelihood of

continuing to use these methods by reinforcing and rewarding their aggressive reactions.

Also, Simons, Johnson, and Conger (1994) found that parental disregard, inconsistency and uninvolvement increases a child's risk for problem behaviours.

Treatment Implications

The above literature review suggests several key treatment implications in the following areas: therapist use of self; family perceptions of time and character flaws; working with subsystems; teaching problem solving and communication skills; promoting empathy; use of behaviour modification, and; use of rituals.

CHAPTER 3: FAMILY THERAPY INTERVENTIONS DURING PARENT-ADOLESCENT CONFLICT

Structural Family Therapy

According to Minuchin (1974) Structural Family Therapy is : "a body of theory and techniques that approaches the individual in his social context" (p. 3). He further elaborates by stating that the goal of this therapy is to change the organization of the family which consequently changes the individual positions of each family member. Minuchin postulated that this creates experiences of change in each member. As Minuchin stated: "By changing the relationship between a person and the familiar context in which he functions, one changes his subjective experience" (p. 13). This is the foundation of family therapy. The therapist joins the family with the goal of changing the family organization in such a way that the family members' experiences change. The therapist attempts to help the family learn and utilize new transactional patterns. These changes create new circumstances and perspectives for individual family members. Consequently, "the changed organization makes possible a continuous

reinforcement of the changed experience, which provides a validation of the changed sense of self (p. 13).

Overall, Minuchin stated that Structural Family Therapy is a therapy of action with the purpose of modifying the present versus exploring and interpreting the past. He identified three properties of the family system: 1) a transformation in a family structure will produce at least one possibility for further change; 2) the therapist joins the family to repair or modify the family's own functioning so that it can perform these tasks better on its own, and; 3) the family system has "self-perpetuating properties" - once change has been made the family will preserve that change.

Minuchin (1974) defines a family as a system that operates through transactional patterns and describes family structure as containing an invisible set of "functional demands that organizes the ways in which family members interact" (p.51). He further explains that patterns of how, when and to whom to relate are established with repetition of transactional patterns. These patterns form the basis of the system and regulate family members' behaviour. He identified two systems of constraint that maintain these transactional patterns which regulate behaviours in the family: 1) generic - universal rules for governing family organization such as power, hierarchy and complementarity, and; 2) idiosyncratic - the system maintains itself by offering resistance to change beyond a certain point and maintains preferred transactional patterns for as long as possible.

Inherent within these constraints are the concept of subsystems and boundaries. According to Minuchin (1974), subsystems can be formed by generation, by sex, by interest, or by function. These subsystems allow a family system to differentiate and carry out its functions. Each individual belongs to different subsystems and has different levels of power in each one. In addition, differentiated skills, facilitated by different complementary relationships are learned within different subsystems. For example, a woman can be a mother, daughter, wife, or niece. The boundaries of a subsystem are the rules defining who participates and how. Their function is to protect the differentiation of the system. It is essential that the boundaries of subsystems are clear in order to allow for proper family functioning. Boundaries must be adequately defined to allow subsystem members to carry out their functions without unnecessary interference. Minuchin further states that a useful parameter for evaluating family functioning is the clarity of the boundaries. He defines three types of these transactional styles on a continuum: disengaged, clear, and enmeshed. A disengaged family system is identified by overly rigid boundaries and difficulty in communication across subsystems. An enmeshed family system is characterized by increased communication and concern among family members and blurred boundaries. Minuchin warns that most families have enmeshed and disengaged subsystems and it is only at the extreme that areas of "pathology" maybe possible. According to Minuchin a boundary problem is " a problem of

negotiating appropriate rules for the formation of new subsystems. It is also a problem of inappropriately maintaining transactional patterns" (p. 23).

Brief Solution Focused Therapy (BSFT)

According to Walter and Peller (1992) Brief Solution Focused Therapy is based on the question: "How do we construct solutions?" and includes the following presuppositions about solutions: they exist; there are more than one; they are constructible - by the therapist and client; they are constructed/invented not discovered, and; this process can be "articulated and modelled". They offer the following three steps for constructing solutions: 1) define what the client wants (versus what he does not want); 2) look for what is working and do more of that, and; 3) do something different if your approach doesn't seem to be working. Brief Solution Focused Therapy, according to these authors, is an interactional experience between client and therapist where all views are equally valid, problem information is not necessary to gather, and the emphasis on solution or goal talk is essential.

Walter and Peller (1992) identify the following 12 assumptions of a BSFT approach:

1) Advantages of a Positive Focus - focusing on the positive, on the solution, and on the future facilitates change in the desired direction. Therefore, focus on solution-oriented talk rather than on problem-oriented talk;

2) Exceptions Suggest Solutions - exception to every problem can be created by therapist and client, which can be used to build solutions;

3) Nothing is Always the Same - change is occurring all the time;

4) Small Change is Generative - small changing leads to larger changing;

5) Cooperation is Inevitable - clients are always cooperating. They are showing us how they think change takes place. As we understand their thinking and act accordingly, cooperation is inevitable (deShazer, 1982, 1985, 1986; as cited in Walter and Peller, 1992);

6) People Are Resourceful - people have all they need to solve their problems;

7) Meaning and Experience Are Interactionally Constructed - meaning is the word or medium in which we live. We inform meaning onto our experience and it is our experience at the same time. Meaning is not imposed from without or determined from outside of ourselves. We inform our work through interaction;

8) Recursiveness - actions and descriptions are circular;

9) Meaning Is in the Response - the meaning of the message is the response you receive (Bandler & Grinder, 1979; as cited in Walter & Peller, 1992);

10) The Client is the Expert - therapy is a goal or solution-focused endeavour, with the client as the expert;
11) Unity - any change in how clients describe a goal (solution) and/or what they do affects future interaction with all others involved, and;
12) Treatment Groups Membership - the members in a treatment group are those who share a goal and state their desire to do something about making it happen.

Walter and Peller (1992) also outline five "rules of thumb": 1) if it works, don't fix it; 2) if everything you are doing is not working, do something different; 3) keep it simple; 4) if you want to do therapy briefly, approach each session as if it were the last and only time you will see that clients, and; 5) there is no failure, only feedback.

Similarly, Nichols and Schwartz (1995) stated that the overall emphasis of Brief Solution Focused Therapy (BSFT) is not to focus on problems but to concentrate more on the future by having clients examine actual solutions that have already worked or may work. In addition, Brief Solution Focused therapists maintain that clients have the skill and desire to change and that the means of change is facilitated by generating achievable goals specific to the individual, using solution language, and emphasizing existing strengths (Nichols & Schwartz, 1995).

Nichols and Schwartz (1995) identify the following two assumptions of BSFT: 1) assume that solutions can be found easily and quickly; and, 2) small change can "snowball" into bigger changes. They also identify four types of questions used in sessions: formula tasks, miracle questions, exception finding questions and scaling questions. One of the formula questions, given in the first session, is to ask clients to identify the things in their life and relationships that they want to continue. Another question is to ask "What has improved since our last phonecall/meeting". This shift in perspective helps to promote a more positive outlook and seems to build on itself (Nichols & Schwartz, 1995). The miracle question is: "Suppose one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?" (Nichols & Schwartz, 1995). According to Nichols and Schwartz (1995) this question helps clients to develop a "problem solving mind set" that facilitates a clearer vision of their goal. Exception questions are used to examine times in the past when the problem does not occur. By examining the circumstances where exceptions occur clients may find clues to what is helpful in dealing with or eliminating the problem. Exception finding questions are also useful in helping the client to see that the problem is not as overwhelmingly pervasive as they may have first thought. Finally, scaling questions are used to help clients recognize and build upon small change and improvements. For example a client may be asked by the therapist, "On a scale of 1-10 (1

being "no arguing at all" and 10 being "constant, non-stop arguing") how was your week?" Then the therapist might ask, "What would it take to move your score from a 9 to an 8?" In this manner, the client and therapist can explore ideas and solutions and move toward the client's goal together while marking improvements.

CHAPTER 4: PRACTICUM SITE AND PROCEDURES

Overview

The committee members for this practicum include Dr. Barry Trute and Dr. Diane Hebert-Murphy from the University of Manitoba and Mr. John Britton from Kinark Child and Family Services, Peterborough, Ontario. Since this practicum was completed outside of the University setting, Dr. Barry Trute provided primary academic supervision and Mr. John Britton provided primary onsite supervision. Primary onsite supervision occurred on a regular weekly basis for a minimum of one hour and included the following: review of cases specific to this practicum and methods of intervention; review and critique of student-client video tapes; co-facilitation of 1-2 sessions. Dr. Barry Trute met with this student, in Winnipeg, half way through the placement in order to review case progress and to suggest relevant readings to advance practice learning.

The client population for this practicum included voluntary families who were self referred to Kinark Child and Family Services, Peterborough, Ontario. Four of the five families had, as a presenting problem, identified some form of parent-teen conflict that had created enough distress in the family that counselling was sought. The fifth family involved conflict with an 11 year old boy who was diagnosed with Attention Deficit Hyperactivity

Disorder (ADHD). Presenting issues for these families included verbal and physical conflict/aggression, criminal activity, illegal drug use, and behaviour management concerns. For the purpose of this practicum an adolescent was defined as age 13-17.

It should be noted that in addition to the five cases described above, this student also ran a separation/divorce group for 10 children aged six to eight which coincided with a parent's group run by another worker at the agency. In addition, this worker served approximately 15 other family cases involving children (applying a mixture of SFT and BSFT), and was included in the regular "clinic duty" rotation which involved the initial meeting and assessment of families on a waiting list for Kinark.

Setting

The setting for this practicum was at Kinark Child and Family Services in Peterborough, Ontario. Kinark is a well established children's mental health centre with seven locations across Ontario. Kinark is one of the largest and most respected child and family counselling services in Ontario and was established as a non-profit organization in 1984. Kinark is funded by the Government of Ontario and through private and corporate donations. Kinark operates its seven Program Centres in Ontario at the request of the

community and of the Ministry of Community and Social Services. Kinark provides services for individuals, families, couples and groups. In addition they provide short term residential treatment and specialized schooling programs for children and adolescents. Special classes have been developed in cooperation with local school boards and are run by counselors and educators. The focus of these classes is to reintegrate children into the traditional school system or a suitable alternative as quickly as possible. Kinark also offers the "Families First Program" which is involves intensive treatment in the family home. This goal of this program is to prevent children from requiring out-of-home placement. Finally, Kinark offers a "Respite Relief" program which includes parent-to-parent counselling, in-home relief, weekly outing with a child or youth, and short term out-of-home placements for children of families at critical moment of stress.

Duration

The practicum placement began September 3, 1996 and ended March 5, 1997. It included four days per week (Monday to Thursday) of placement from September to December, and three days per week from January to March.

Evaluative Measures

Evaluative measures included the FAM III administered pre and post intervention, as well as a Client Satisfaction Questionnaire currently used by Kinark. In addition, all Kinark clients complete a SCIS form (see Appendix A) at intake. Recordings were completed as per the regulations and guidelines of Kinark Child and Family Services.

The Family Assessment Measure (FAM)

The Family Assessment Measure (FAM) is a self report questionnaire designed to assess three components of family functioning represented by the following scales: 1) General Scale - focuses on the family as a system; 2) Dyadic Relationships Scale - examines relationships between pairs in the family; and, 3) Self-Rating Scale - individual's perception of his functioning in the family (Skinner, Steinhaur & Santa-Barbara, 1983). The basic dimensions assessed by the FAM are represented by the following subscales: Task Accomplishment, Role Performance, Communication, Affective Expression, Involvement, Control and Values and Norms. The entire FAM takes approximately 30-40 minutes to complete. According to its authors, the FAM is able to discriminate between clinical and non clinical families.

For the purpose of this report, only the General Scale was administered to parents and teen members. In some cases, where a child was between the ages of 10 and 12 the scale was also administered. As with any measure, the FAM is intended to compliment, enhance and be used in conjunction with clinical judgment and, as such, should not be used in isolation as a sole source of diagnostic information (Skinner et al., 1983).

According to the Skinner et al. (1983), the reliability co-efficient for internal consistency of the General Scale is .93 for adults and .94 for children. The reliability of the subscales range from .65 (defensiveness) to .87 (social desirability) for adults and from .60 (task accomplishment) to .87 (social desirability) for children. They state that the main goal of the family is the successful achievement of Task Accomplishment: basic, developmental and crisis tasks. Tasks are accomplished by: 1) task or problem identification; 2) exploration of alternative solutions; 3) implementation of selected approaches; and, 4) evaluation of effects. They further state that successful Task Accomplishment involves the differentiation and performance of various roles. Role Performance involves the following: 1) the assignment of specified activities to each family member; 2) the willingness of these family members to assume to given roles; and 3) the actual act of these family members carrying out their given roles. Skinner et al. stress that, in order for role performance to occur, effective communication must be ongoing. They define the goal of effective communication as "the achievement of

mutual understanding, so that the message received is the same as the message intended" (p. 1). However, they warn that it is critical that the receiver be open and available to the message being sent, at the reception phase of communication, in order to limit distortions in communication. Affective Expression plays an integral part in the communication process as it can hinder or assist different aspects of Task Accomplishment and successful role integration. They state that this type of communication includes the content, intensity, and timing of the feelings involved and can be blocked or distorted by stress. Involvement - the degree and quality of family members' interest in each other - can also hinder or assist Task Accomplishment. There are five types of involvement: an uninvolved family, a family which expresses interest devoid of feelings, a narcissistic family, an empathic family, and an enmeshed family. In addition, they stress the importance of the ability of the family to "meet the emotional and security needs of family members while simultaneously supporting each members' autonomy of thought and function".

According to Skinner et al. control is the process by which family members influence each other. Crucial aspects of control relate to whether or not the family is predictable versus inconsistent, constructive versus destructive, or responsible versus irresponsible in its management style. The four prototype styles (rigid, flexible, laissez-faire, and chaotic) may result from combinations of the above aspects. With effective control the family

should be able to successfully maintain ongoing operations as well as adapting to shifting task demands.

Finally, Values and Norms, according to Skinner et al. "provide the background against which all basic processes must be considered" (p. 2). The authors identify the following important aspects of Values and Norms: explicit versus implicit family rules; latitude for family members to determine their own attitudes and behaviour; and whether family norms are culturally consistent.

The Client Satisfaction Questionnaire

The Client Satisfaction Questionnaire was administered to each family member post intervention and was tailored to suit research purposes of Kinark Child and Family Services. The scale included nine questions about the service provided to the client. Answers were recorded on a Likert scale ranging from "strongly agree (1)" to "strongly disagree (5)". There was one question on the overall quality of service which ranged from "very good (1)" to "very poor (5)". In addition, three open ended questions were included: The thing I like best about my involvement with Kinark was ... ; If I could

change one thing about Kinark, it would be ... ; Any other comments or suggestions.

CHAPTER 5: CASE STUDIES

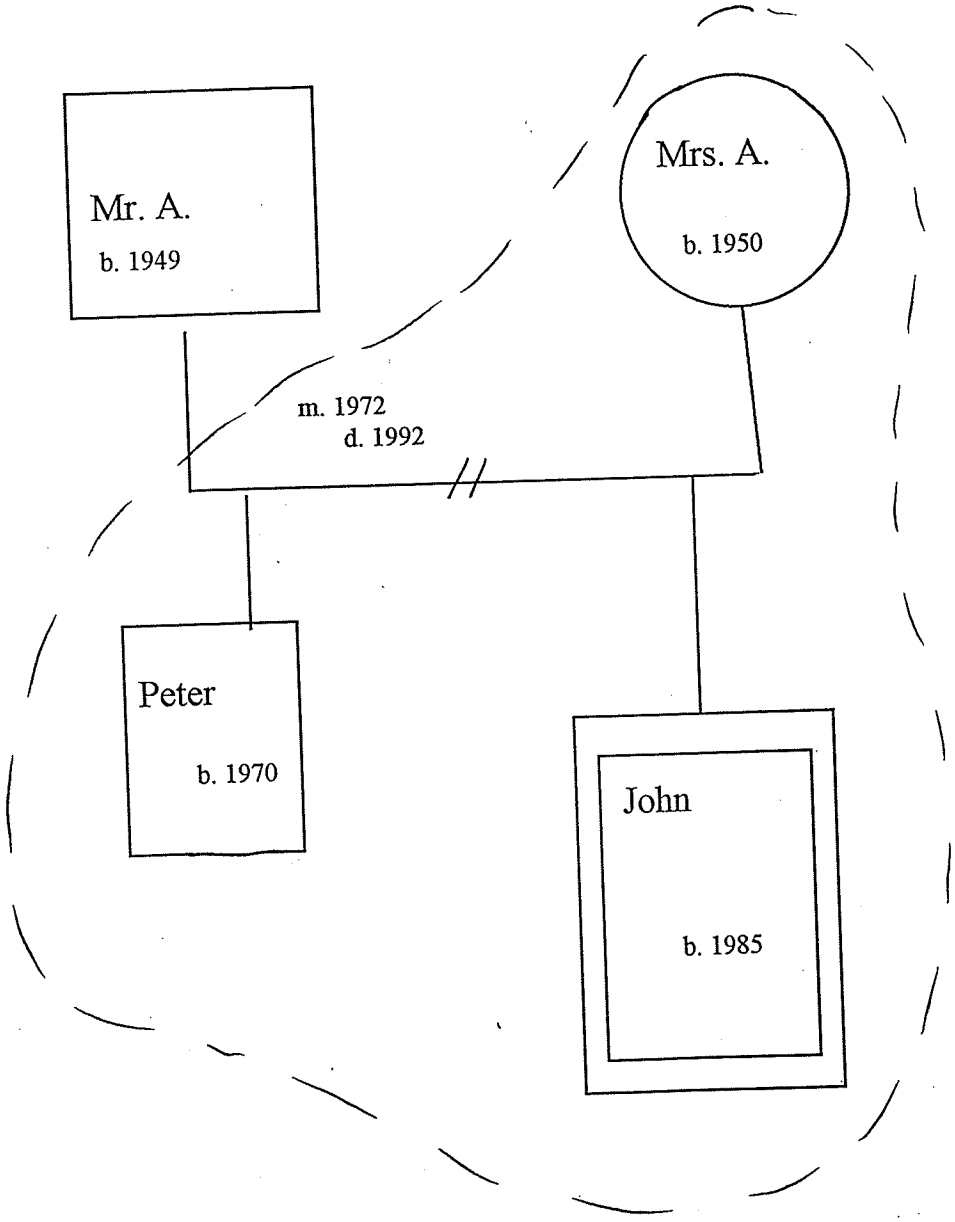
Introduction

The following chapter discusses three cases in detail - one family with whom Structural Family Therapy was used, one family with whom Brief Solution Focused Therapy was used and one family with whom a combined SFT and BSFT approach was used. In each case an initial hypothesis is presented based upon presenting problems and information obtained from the FAM. Specific interventions are also discussed relevant to the presenting problem and the primary model of intervention.

This chapter also discusses the course of therapy for each of the families as well as an evaluation of the family following therapy. The evaluations take into account reports from the family, my own impressions and assessments, and the results of the FAM's administered pre and post test.

The "A" Family - Structural Family Therapy

Genogram



Background and Referral Information

Mrs. A. referred her 13 year old son, John, to Kinark in consultation with her family doctor. Mrs. A. described John as having witnessed violence in the home and stated that he is now being physically and verbally aggressive toward her. Mr. and Mrs. A. have been separated since 1992, following 20 years of marriage, and Mrs. A. stated that her ex-husband was physically, verbally and mentally abusive toward her. Mrs. A. has custody of both John and his brother, Peter (age 18). John has regular contact with his father, who lives nearby, and enjoys visiting him. John has also been diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) and is currently taking Ritalin twice daily during school hours. John, Peter, and Mrs. A. live in subsidized housing and Mrs. A. collects family benefits. Mrs. A. reports a strong relationship with her mother and views her as an important source of support. Mrs. A. has a history of alcohol overuse.

Initial Interview and Hypothesis

Initial Interview

Mrs. A. and John attended the first session together. Both were greeted warmly and, as an initial joining technique with John, I commented enthusiastically on his (obviously) new and stylish haircut. John seemed very pleased. Both John and Mrs. A. presented as relaxed and cheerful. This session was co-facilitated by myself and my supervisor, Mr. John Britton.

To begin with, Mrs. A. (and then John) were asked, "What brought you here today? Why did you come and what do you hope to accomplish?" Mrs. A. stated that approximately five months previously John began to verbally and physically abuse her and she wanted this aggression to stop. She described the following behaviours: calling her "disgusting" names, poking and pinching her, and on one occasion swinging a lacrosse stick and hitting her on the leg. Mrs. A. stated that she received bruises from many of John's assaults and that she doesn't know what to do to stop this pattern. She said that she often has to call upon her 18 year old son, Peter, to intervene and discipline John for her. John stated that he was worried about his mother's health particularly regarding her drinking habits (and driving). In the course of discussion it became apparent that John had suffered many losses recently and was sincerely worried about his mother's health. John

also stated that he wished he and his mom would spend time together "doing things".

John spends much time visiting his father who lives nearby. He sounded excited and eager about his visits with his father because they spend a lot of time doing things together. Mrs. A. said that she is worried about Mr. A's influence on John because of the past abuse. On the other hand, Mrs. A. said that Mr. A. still helped her around the house occasionally for such things as putting up the storm windows. She was unable to give any examples of how John's current relationship with his father was detrimental. Both Mrs. A. and John stated that arguing between them can be sparked very easily. John expressed a sincere desire to end the violence. I encouraged Mrs. A. to bring her son, Peter, to the next session.

Due to the violent nature of this relationship this session ended with a verbal contract between John and Mrs. A. John agreed to physically leave his mother alone and Mrs. A. agreed to cut back on her drinking and not drink and drive. Mrs. A. admitted that recently she had been drinking more often. She stated that many evenings she would drink up to a full bottle of wine or three to four "rum and cokes". She stated that she had been feeling "down" since her father died a year ago and since her mother's recent decline in health. John's recent violence also contributed to her feelings of depression and she said she used the alcohol to "unwind". Mrs. A. and John both stated that during certain periods in her life Mrs. A. drank more

frequently and then would cut back significantly. Mrs. A. has never been treated for alcohol abuse. At this point, I did not believe that her alcohol abuse was serious enough for independent treatment.

Hypothesis

I hypothesized that John's sudden onset of violence may have been related to his mother's drinking patterns. I also believed that his reaction may have been a type of grief response to his grandfather's death. Mrs. A's father died of cancer two months before John's violence began and her drinking increased considerably. John expressed a sincere worry about his mother's health and also stated that he was afraid that she would die. He also said he worried that she was "drinking her life away" and that when she wasn't drinking she was sleeping. This leaves a young adolescent boy anxious, fearful, unsupervised and with minimal contact of the parent with whom he resides. In addition, John witnessed violence in the past between his father and mother and his violence may be also be the result of a learned behaviour.

I further hypothesized that as Mrs. A's drinking decreased and her positive interaction with John increased, along with effective use of consequences and discipline for John's behaviour, that John's violence would end.

Treatment Goals

1) For John's physical and verbal abuse toward his mother to stop and for Mrs. A. to feel more confident, competent and effective in disciplining and providing guidelines for John.

2) To increase positive contact between Mrs. A. and John. John's need for attention will be addressed and he will worry less about his mother's health as she is feeling active and healthy and able/willing to interact with John.

3) Strengthen and develop hierarchy and boundaries between John and Mrs. A. for the following reasons: John and his mother seem to argue like partners (boundary and hierarchy). Mrs. A. often feels she has to have her 18 year old son intervene to discipline John rendering her less powerful (hierarchy and boundary with 18 year old son).

4) For Mrs. A. to cut back her drinking and to never drink and drive.

Course of Therapy

Session Two

Mrs. A. and John arrived. Peter did not come to this session. Mrs. A. said that he was "out" when they left for their appointment. We discussed the importance of having Peter attend in order to try to understand his relationship with John, his current role in the family, and to encourage him to provide more information and another perspective on the family. Mrs. A. said that she would bring him next time.

We met with Mrs. A. alone first. We discussed how similarly powerless she feels with John as when she was with her husband. We investigated her strength in overcoming her "powerlessness" by calling the police on her husband and asserting herself by laying charges and consequently leaving him to parent two sons on her own. I attempted to link this assertive behaviour that Mrs. A. demonstrated in the past with needed intervention with John. We discussed a "high risk" plan of calling the police if John was violent. Mrs. A. stated that she was reluctant to do this as "John is a good kid, he's excellent most of the time" and she preferred to try the counseling before resorting to calling the police. She agreed that if the violence escalated or if she felt very threatened she would call the police for help.

I then met alone with John alone to discuss his concerns. He described many areas of loss that he has experienced in the recent past including the loss of his parents and family. John stated that he wished his parents were still together and that they "got along". John also said that he was worried about his mother's health. He described her as a "couch potato" who was wasting her life away by drinking, smoking, and often sleeping all day. John also stated that his grandfather died last year, his other grandfather died four years ago, his grandmother is unhealthy and that two of his dogs died in past two years. John stated that sometimes he feels like life "sucks" and admitted that he has thought of suicide in the past but has decided that this alternative "sucks" also. I checked for the existence of a current suicide plan (No) and his future orientation was good. John said that, on the positive side, he has a girlfriend and, when asked, stated a strong desire to "work things out with mom". I asked permission from John to share some of this information with his mother particularly regarding past suicide thoughts and his genuine commitment and desire to work things out with his mother.

I then met with John and Mrs. A. to discuss . John and Mrs. A. spent the rest of the time negotiating and writing their own contract for the week.

Session Three

John and Mrs. A. reported four "violence free" and enjoyable days in the last week. Both seemed pleased, proud and happy about this improvement. Mrs. A. stated that for three of these days she had stopped drinking. They then reported that the other days were "bad". John hit his mom with a lacrosse stick and she was bruised. I reiterated the role of police intervention. I further investigated the pattern of abuse. Mrs. A. contended that John would hit her when she was literally "doing nothing". I hypothesized that it is Mrs. A's very inactivity (lethargy, depression?, hangover?) and withdrawal from "life" (as described by John) that raises anxiety in John and consequently he goes to drastic (negative attention seeking) measures to gain her attention. I challenged Mrs. A's need to be less withdrawn from John and to engage him in more conversations, hugs, touches, interactions, etc. This was practiced in session. John and Mrs. A. agreed to keep their current contract and also to plan an outing together. The particulars of the outing were planned and discussed and practiced during session.

Session Four

Both Mrs. A. and John reported a good week. They stated that there had been no violent incidents and that Mrs. A's drinking had lessened. In addition, they reported that they were spending more time together "doing things". They both stated that they were very pleased with their hard work and progress. I met with Mrs. A. alone to discuss impact of her withdrawal and drinking on John and how she can cope with these feelings. She stated that she would focus on strengthening herself through prayer and support from her family. This was the first time religion was discussed between us. Mrs. A. stated that she had been raised as a Roman Catholic and that she still attended Mass sporadically. She described her Religion as being most useful to her "in times of trouble" and commented on the peacefulness she experienced through prayer and reflection. While both of her sons attend Catholic schools neither of them attend Church.

Met with Mrs. A. and John together. They stated that they have a hard time thinking of things to do together. I taught a "brainstorming" technique which was practiced in session and used to plan their next outing together.

Mrs. A. agreed to bring Peter next time. Mrs. A. requested that we skip next week's meeting and come in two weeks time "as a reward". I interpreted the "reward" as taking a break from the hard and emotional work that they were doing in therapy. Both John and Mrs. A. stated that

they found our sessions helpful but hard work. I also wondered if Mrs. A. thought or hoped that they had already found a "quick fix" to their problems so that no further effort was required.

Session Five

Mrs. A. and John reported that the hitting had increased again up to four times per week. Mrs. A. also stated that she had been drinking more frequently. They both reported that they were spending more time together renting movies, getting groceries, watching football, visiting family. In retrospect, I hypothesize that the "week off reward" may have been Mrs. A's way of saying that she wanted a break from the effort of keeping her drinking to a minimum and that she was weary of working on her relationship with John. I also hypothesize that John's increase in violence was a response to Mrs. A's increase in drinking as his fear for her health and frustration over her lack of interest (disengagement) in him resurfaced. We discussed specific behavioural interventions. Mrs. A. and John decided on the following: 1) if John feels himself escalating he will go to the basement to "hammer a nail"; 2) Mrs. A. may help John by prompting him to do this; 3) John will try to ask for his mother's attention instead of hitting her; 4) Mrs. A. will leave the house if John is escalating (remove attention from him) and will go to visit a friend or a family member. When she returns a consequence

will be put in place for John (loss of one or more of his privileges). Each of these situations were practiced in session.

Sessions Six to Nine

Mrs. A. and John reported improvement in that John had not hit his mother, but had poked her. The emphasis of these sessions was on completely stopping physical violence. This worker aligned closely with Mrs. A. to give the message: no violence period, verbal or physical. Mrs. A. clearly stated her expectations and consequences to John. Mrs. A. stated that leaving the house was helpful to her and that she would continue to do this. We further discussed concrete consequences to be put in place immediately upon her return, and how to enforce these. For example, if John does not comply with the loss of his TV or phone privileges, Mrs. A. can remove the cable from the back of the TV or unplug the phone and put in a safe place. This allows her to set the consequence in place herself instead of relying on Peter to assist. Mrs. A. had relied on Peter to intervene with John in order to make him follow her directions. Peter was thereby placed in the role of parent for John and supportive partner for Mrs. A. Peter often resorted to physical intervention with John to make him "obey" his mother, and, in fact, Peter himself. Mrs. A. also called on Peter to protect her physically from John, when he was

home, and John was being violent. Peter was rarely home. However, when he was, Mrs. A. seemed to treat him as more of a partner and parent than as her son.

By the eighth session, both Mrs. A. and John reported that physical violence had stopped and verbal aggression occurs once or twice a week. Both reported no violence from John in almost two months and direct verbal abuse at Mrs. A. has stopped but swearing still continues. We reviewed, practiced and reinforced previously discussed interventions.

Follow up Phone Call

Mrs. A. and John did not attend the last scheduled appointment. When I called Mrs. A. stated that she was ill. We agreed to terminate at this point. John has not engaged in any physical violence in almost three months.

Pages misnumbered -- there is no page 53.

Discussion of Measures (FAM and Client Satisfaction)

FAM

John's pre-intervention FAM III (see Table #1, Appendix A) graph showed all subscales to be in the "family problem" stage. Following intervention over half of the subscales were in the average range while Task Accomplishment and Involvement improved and Affective Expression remained the same (see Table #2, Appendix A).

Mrs. A's FAM scores indicated improvement on all subscales (Values and Norms remained the same) bringing scores closer to the average range (see Tables #3 and #4, Appendix A).

The FAM's supported the conclusion that both John and Mrs. A. were able to build on their strengths. The change in John's perception of involvement and the consequent lowering of other scores supports the hypothesis that Mrs. A's under-involvement with John may have been causing distress for him. Both Mrs. A. and John reported that Mrs. A's drinking had lessened but was still present. I speculated that this factor affects each of John's scores: as Mrs. A. drank less and became more involved with John and began to implement more parental type authority the boundaries between the two became clearer and less chaos resulted in the family.

Similarly, Mrs. A's score improvements, particularly for Task Accomplishment and Role Performance, support her success at regaining some sense of mastery in effecting change in her family as well as supporting the clearing of boundaries between herself and John as she took on a more effective parental role.

My own observations supported the family's reports of change. Both John and Mrs. A. spoke proudly of their accomplishments and the changes in John's behaviour.

Client Satisfaction Questionnaire

Both Mrs. A. and John rated the overall service they received as "very good (1)". Individual rating scores were consistently "strongly agree (1)" or "agree (2)". They both identified that what they liked best was the fact that the fighting and the abuse had ended. John commented that he and his mother do more together now and that she drinks less. Mrs. A. reported that the verbal abuse and language had improved (see Appendix B).

Discussion

Structural Family Therapy was used with family A. At the initial meeting I focussed on the SFT task of "joining" with Mrs. A. and John. Specifically, I asked each of them to describe the problem as they saw it. In order to show support for the family hierarchy I addressed this question to Mrs. A. first. When I turned my attention to John I relaxed my body posture and reclined in my chair in order to more approximate his body position. I gave both Mrs. A. and John my undivided attention when they were speaking (for example, eye contact, my body leaned forward) and attempted to use their respective language patterns. I utilized this type of joining procedure throughout the course of therapy.

Also, during this initial meeting I focused on family interactions and attempted a preliminary diagnosis. I noticed that Mrs. A. would often make a statement or observation about their pattern of arguing and would then turn to John for confirmation by asking "Isn't that right, John?" This immediately alerted me to boundary and hierarchy issues. In addition, I realized that both Mrs. A. and John directed their communications to me and demonstrated some degree of difficulty expressing themselves to each other. In order to address these interaction and facilitate communication I continuously directed them to address each other instead of me. In addition, I frequently used Minuchin's (1974) "springboarding" technique. For

example, after listening to Mrs. A. I would paraphrase her concerns to John by saying "Your mom says that you are an aggressive person. Do you agree with her? What do you want to say to her about this?" I also had John and Mrs. A. reenact their arguments for me so that I could look for patterns of interaction and themes to base my hypothesis on. Due to their consistent arguing and fighting I hypothesized that Mrs. A. and John were enmeshed and that no clear hierarchy existed in this family. I also hypothesized that when Mrs. A. was drinking she disengaged from John. John's pattern of response to this was to aggravate and assault her until he could gain her attention again. Given these structural hypotheses my goal was to attempt to restore Mrs. A. to a position of leadership in the family and to strengthen the boundaries between the parental and sibling subsystems.

In order to achieve these structural goals I attempted to highlight and modify many of their interactions. One method that seemed particularly effective with Mrs. A. was to point out to her the patterns I was seeing. For example, I would say to her "I've noticed that you keep checking your answers with John to see if he agrees with you." She would then realize that this behaviour needed to be changed and we would discuss alternatives. To reinforce this and other new behaviours I would have Mrs. A. and John reenact their fights utilizing their new alternatives. Since the focus was on establishing Mrs. A. as the "head of the family" and strengthening the boundaries between the parental and sibling subsystem I reinforced every

possible success for them in order to help shape their competence in these areas.

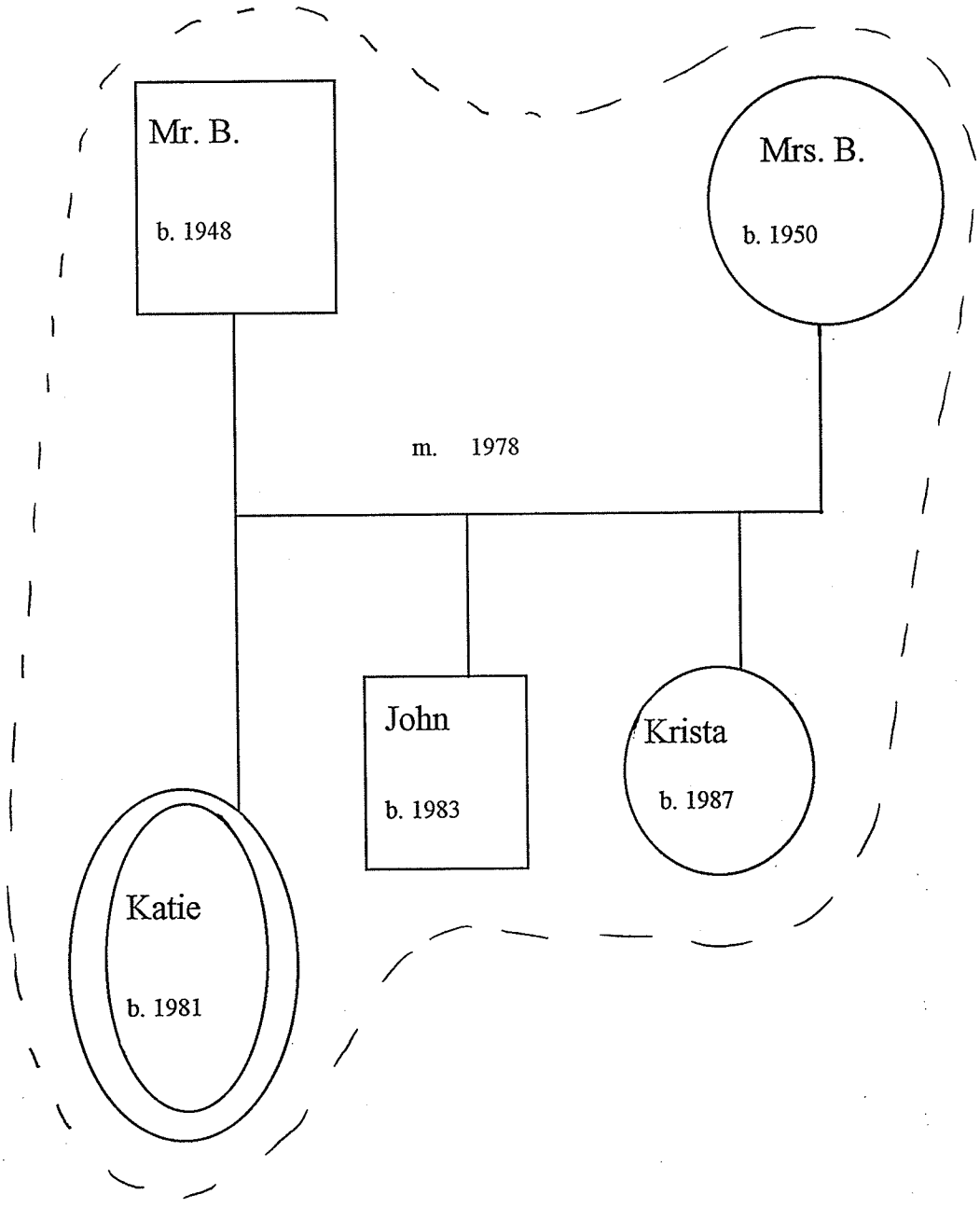
Since Mrs. A. never actually brought Peter to a session it was difficult to address these goals with the whole family. Had Peter attended I would have attempted to strengthen the sibling subsystem, and its boundaries, by meeting with Peter and John together. During these sessions I would have followed Carter and McGoldrick's (1989) suggestion of addressing the adolescents' values and beliefs on a range of topics from life and love to family, friends, and responsibilities. In addition, I would have focussed, in family sessions, on strengthening boundaries between Mrs. A. and Peter. Mrs. A. needed to be elevated to the role of parent and Peter needed to resume or take on the role of young adult son and sibling in the family. Instead Mrs.. A. was treating and relying on Peter as a partner. I hypothesized that this elevation in power for Peter was why Mrs. A. was unable to "make" him come to our sessions. I still addressed these issues of boundary and hierarchy with Mrs. A. and challenged her interactions with Peter that she described. As the sessions progressed and as Mrs. A. gained some control over the family herself she reported that she no longer relied on Peter for as much help.

There are several aspects of this case that, upon retrospect, I would have done differently. First, I believe I downplayed or failed to recognize the significance of Mrs. A's alcohol abuse. I can see how her addiction

obstructed the work I was attempting to do with her and John. At the very least, more specific goals regarding her drinking should have been formulated. I also should have considered addiction counselling for her. I also now question the role that John's violence played in this family. In retrospect, I now hypothesize that John's behaviour may actually have been a method of bringing attention (and thereby intervention) to his mother's addiction and his fear for her health and safety. Secondly, despite the above hypothesis regarding John's behaviour, I should have taken on a stronger and more authoritative role with John, by aligning more closely with Mrs. A. to support a definite "no violence" rule in the home. Finally, I believe that I should have continued to impress upon Mrs. A. the importance of having Peter attend. When Peter did not attend I should have explored in more detail why Mrs. A. was unable, or unwilling, to bring him to a session. I believe that there was a rich amount of information and potential assistance for the family that was missed through Peter's absence.

The "B" Family - Brief Solution Focused Therapy

Genogram



Background and Referral Information

Mrs. and Mr. B. referred their 16 year old daughter, Katie, to Kinark for the following reasons: unmanageable behaviour, authority conflicts, temper outbursts, destruction of property, and non compliance. At the time of referral parents stated clearly and emphatically that Katie was the sole symptom bearer in the family and that she needed individual anger management counseling. Parents initially presented as being unwilling to consider the usefulness of family counseling and reported that they had "been everywhere for counseling and found it unhelpful". Mr. B., in particular, seemed "stuck" in viewing Katie as the symptom bearer. He reported that he perceived past counseling as wrongfully identifying him as the "mean, inflexible, problem" (scapegoat) in their family. The majority of the conflict seemed to centre around father and daughter with mother acting as a mediator and peacemaker by primarily trying to pacify Katie. This often took the form of undermining her husband's authority either covertly or overtly, as she has stated that she thinks that Mr. B. is too strict and rigid. This is an intact family who is also additionally stressed by the chronic disability of their youngest member, Krista, who has severe Cerebral Palsy and requires constant care.

Mr. and Mrs. M. have been married for 20 years. Mr. B. is a machinist and Mrs. B. provides daycare for a three year old in her home. Mrs. B. also provides ongoing daily care for Krista. John presents as an "easy going" young man and he and Mr. B. appear to have a good relationship. Mr. B. goes to most of John's hockey games and they often go out for lunch on the weekend together. Katie clearly feels left out of this relationship and often stated that she wished that she and her father could do things together again too. She reported that they just can't seem to be in the same room together without getting into an argument. Both Katie and John are in high school. Katie works at a local deli up to 30 hours a week and John delivers newspapers daily.

Initial Interview and Hypothesis

Initial Interview

The original plan was for all family members to attend. Mr. and Mrs. B. gave the explanation that Katie was working and John was needed to look after Krista. I attempted to stress the importance of the entire family attending together.

The initial focus of this meeting was to join with all family members. I had originally planned to start the session, in typical BSFT approach by

asking, "What has improved since our phonecall?". However, since only the parents attended and given their intense emotional level of the parents, their guardedness (parents described a long history of service with different providers in the community all with perceived lack of success) and apparent investment in viewing Katie as the symptom bearer in the family, I decided that such a question would only interfere with the joining process and would alienate the parents even more. Instead I posed the BSFT question to them: "How can I be most helpful to you? How would you like to spend our time together?". This allowed the parents to vent their concerns and provided an initial opportunity for me to begin to join with the parents and engage them in the process of therapy. This beginning phase was BSFT in approach but also followed Tomlinson's (1991) suggestion that interventions should be done first with parents and should focus on their feelings and concerns, and the effect that the conflict is having on them. A further suggestion by Tomlinson was to initially focus on restoring the parents to a level of leadership in the family. This also represents the structural approach of establishing an effective hierarchy. Carter and McGoldrick (1989) also support the role of the therapist in meeting with subsystems in order to provide support and help members to be more objective about their roles as parents and spouses.

Particular attention was given to Mr. B. who seemed overly invested in identifying Katie as the sole symptom bearer in the family. Mr. B. stated

that in the past he has been blamed for the conflict in the family as he has been described as being "too rigid, strict, unrealistic" in his expectations of the teens. This statement by Mr. B. set off warning bells for me as a therapist. Hopkins (1983) warns of the relationship between parental restrictiveness and adolescent rebellion. I began to wonder if some of Katie's behaviour was directly or partially related to her relationship with her father. Similarly, Fraser (1996) argued that aggressive behaviour becomes rewarding for adolescents when parents respond with disproportionate force to demands or conflict. The negative reinforcement from the parent makes it more likely for the teen to continue being aggressive. Katie and her father seemed as though they may have been caught up in a negative cycle of reinforcement. Attempting to break this cycle became my focus.

I then shifted into investigating strengths and positives within the family system, particularly with Katie. Both parents were easily able to identify that Katie was a good student, was responsible at her job and had good friends.

I then attempted to help parents identify times when the conflictual behaviour with Katie was not occurring in order to find situations that are "working" and to encourage family members to "do more of whatever it is they are doing at this time". Both parents became "stuck" at this point and said "never". Mr. B. said, "when she's sleeping". I challenged this view and

stated that they had just easily described many strengths in Katie and the fact that she was quite capable of "controlling her anger" at work, school, and with her friends. Mr. B. then stated that Katie was easier to get along with when she came home with an excellent test mark, when her friends were visiting, and when she was getting her own way. The parents seemed quite invested in the fact that Katie was the only person to blame. This concerned me because, as Finchman (1985) stated "perceiving negative behaviour ... may lead to generalization of anger across conflict situations". In other words, feelings of anger become pervasive and generalized to situations that may not have caused anger before. I believed that the parents had to move out of this "rut" in order to more clearly understand and respond appropriately to Katie's behaviour. I then attempted to reframe Katie's role as an "unmanageable teen" by investigating the impact of some of the stressors in Katie's life that may add to the adolescent "angst" typical at this stage: working 30 hours per week at a part time job, doing well in school preparing for tests and assignments, limited social time due to hectic schedule. Parents agreed that Katie had a very heavy load and that this may contribute to her stress level and some of the short temperedness that was evident.

I then attempted to investigate the sibling system through the parents. Parents identified that both teens were very caring of Krista and were

involved in her caregiving, at times. In addition, parents noted that John often sticks up for Katie. I began to wonder about over control by parents in this family: Mr. B. began to consider talking to Katie's employer to help have her hours reduced without consulting Katie first, Mrs. B. wrote a note to excuse Katie from two classes so that she could study for a test because she had been too busy with work to study.

At the end of the session, I again emphasized the importance of involving the entire family. Mr. B. reiterated to me that Katie needed anger management counseling. Parents seemed reluctant to be involved but stated that they would do their best to bring Katie, John, and Krista in so that I could meet with them as a family, as well as in subsystems.

Hypothesis

I hypothesized the following:

1) Mr. and Mrs. B. needed to work more effectively as a team. I hypothesized that Mr. B. was "forced" to be or appeared to be overly rigid due to a covert alignment between Katie and Mrs. B. Mrs. B. stated that she often thought that her husband's approach and consequences were too harsh

so she compensated by releasing Katie from her groundings (etc.) when Mr. B. had put them in effect.

2) Mrs. and Mr. B. were not treating Katie in an age appropriate manner with the rights and responsibilities of a sixteen year old. They often rescued her and took responsibility for her actions and well-being.

3) Katie had a lot of power in this family. She was able to be rude to her parents and have behavioural outbursts, similar to violent temper tantrums, and still "get her own way".

4) to help parents restore clear, consistent and unanimous rules and limits in the home in order to :

a) lessen Katie's sadness and anger outbursts (Compernolle, 1981);

b) give parents a feeling of empowerment;

c) lessen the focus on blame and anger and increase distance by encouraging cool, clear, logical consequences.

I hypothesized that the most important initial change was for Mr. and Mrs. B. to work together and support each other as part of a parental team thereby giving consistent messages to Katie and hopefully lessening the tension in the marital subsystem. I further hypothesized that if they could shift toward allowing Katie to experience appropriate and logical consequences for her behaviour and at the same time allow her the freedom and responsibilities of an adolescent there would be less fighting in the home.

In addition, I hypothesized that if there could be less fighting in the home Mr. B. and Katie could begin to foster a closer relationship together.

Treatment Goals

1) To create a strong parental subsystem and hierarchy within the family. As parents work together consistently as a team they will be better able to support each other, lessen the conflict in their subsystem and provide Katie and John with age and stage appropriate parameters. I theorized that, as Katie is less able to have her mother align with her and as reasonable consequences are consistently enforced the conflict should lessen.

2) To challenge the role of Katie (and Mr. B.) as primary symptom bearers in this family. This joining technique should help lower defenses in both members and help to actively engage them in therapy as well as assist all family members in seeing the impact of their role in the conflict.

3)To help establish age and stage appropriate rules, expectations and responsibilities within the family.

4) To help strengthen the father-daughter relationship through positive contacts.

5) To assist family members with anger management strategies.

Course of Therapy

I met with the B. family and various subsystems of the family on eight more occasions. Treatment ended as my placement was over. In addition, Kinark had recently changed its policies to allow families a maximum of six visits which the B. family had exceeded. I offered the family another worker which they declined.

Second and Third Session

I met with Katie during the second and third session. Katie and Mrs. B. arrived together and they both requested that Katie meet with me with her mother present until she felt comfortable. I continued to stress the importance of meeting with all family members together.

Katie presented as a bright, articulate and mature 16 year old. She stated that she needed help with her temper and that "it got out of control at times and scared her". In response to the "miracle question" she stated that she wanted a relatively conflict free and close relationship with her father . She rated, on a scale of 1-10, the frequency and intensity of their fighting as currently being a 9.5 and identified swearing as a key component of initiating and maintaining their arguments. We searched for areas and times that did not involve conflict with her father and discussed ways in which Katie could help to limit the fighting.

Kelly did present as a fairly mature 16 year old. However, the fact that she and her mother insisted on a session together gave some potential support to my hypothesis that Katie and Mrs. A. were enmeshed.

Sessions Four to Nine

I met with the family and with various subsystems. I continued to meet with the parents and began to concentrate more fully on the parental subsystem working effectively together. This is where I observed and the parents and family members noticed the most improvement. Mr. and Mrs. B. worked out clear expectations and agreed upon consequences for Katie and John. They helped each other to follow through consistently and

practiced consulting each other before a decision was made regarding their teens. Mr. B. reported relief at having the support of his wife. Mrs. B. reported that she felt less "trampled on" by Katie and could see how these logical consequences made sense. Both parents reported a significant improvement in their relationship as they worked more effectively as a team.

I also met with Katie and John together. This served several purposes. Firstly, I was able to use these sessions to reinforce the "joining" process with them. Secondly, following Carter and McGoldrick's (1989) suggestions we discussed their beliefs and values about life plans, responsibility, education, friends, family and the existing conflict in order to foster support between the siblings and for me to gain a better understanding of them. Meeting with the subsystems separately was important because our next focus was on discussing age appropriate rules and expectations as a family unit. conflict theory, according to Deutsch (1973), maintains that constructive conflict fosters a sense of satisfaction and productivity. I hypothesized that it was important for the family to work together to set these rules for a number of reasons. First, the family members identified this task as their goal. Clear rules and consequences needed to be established in this family. Secondly, this was an opportunity for parents to maintain their authority in the family while still being flexible enough to enter into negotiation with their adolescents. Third, this exercise would be an example for them to base future

constructive conflict situations on. Fourth, conflict theory implies that the sense of satisfaction and productivity may foster more successes in the future.

On the other hand, some of Katie's behaviours began to escalate. I hypothesized that the shift in power and control in this family (from Katie back to her parents) and the clearing of the boundaries between Katie and her mother caused distress for Katie. I also hypothesized that, with time, consistency, and appropriate flexibility, that Katie's outbursts may subside. In the meantime, Mr. B. was encouraged to find as many positives to share with Katie as possible.

Discussion of Measures (FAM and Client Satisfaction)

FAM

Both Mr. and Mrs. B's FAM's showed improvement (see Tables #3 and #4, Appendix A). Mr. B's scores (see Table #3, Appendix A) demonstrated the most dramatic improvement in the family. For both parents, approximately half of the subscales were in the average range demonstrating the improvement that both of them commented on. John's pre and post intervention FAM's (see Table #5, Appendix A) did not seem to change significantly, although the subscales of control and values and norms moved

into the average range. Katie's post intervention FAM worsened, in general (see Table #6, Appendix A). I hypothesized, this may be because of the shift in the family described above. If this is the case, Katie would be experiencing a period of disequilibrium that may explain her rise in scores. It is interesting to note that Katie reported to me that she felt her family had received a significant amount of help. She acknowledged that she did not like all of the changes but understood their importance.

Client Satisfaction Questionnaires

Each of the questionnaires returned (see Appendix B) rated the service the family received as "very good (1)". On the individual sub questions score were primarily "strongly agree (1)" and "agree (2)" except for the question "I received enough service" which was rated as "neither good nor poor (3)". Individual comments included benefiting from the husband-wife team approach, being allowed to voice one's own opinion and being able to give their own suggestions for improvement and change.

Discussion

Many key interventions were used that made this case BSFT. The first session began with a "Formula First Session Task". In order to help family members define their goal more specifically they were asked to observe, between now and the next meeting, what happens in the family that they wanted to see continue happening. This question can also help the family to see that their problem may not be as pervasive as they originally thought. Each session thereafter began with the BSFT questions: "We have an hour together. How do you want to spend this time: How can I be most useful to you and your specific goals?" This approach seemed particularly effective in supporting the process of "joining" with each family member. Mr. B., in particular, seemed to appreciate this approach that did not scapegoat him. He stated that he had been scapegoated in therapy in the past and that consequently he did not want to enter into therapy again. In our sessions, he quickly became a more active participant as a result of the future orientation and solution focused approach that BSFT provides. The beginning question and joining techniques were also empowering for the adolescents who felt they had some "say" in the therapy. Throughout the meetings I consistently emphasized exceptions by asking variations of the question "When is the arguing not happening". Family members were able to begin to see that, although the arguing and upset in the family was pervasive, it was not all

encompassing. Another technique that was useful was the scaling question. This question was used at each session to monitor individual ratings and to generate more solutions. For example, if a family member rated the conflict negatively that week at a nine, out of a possible ten, I would then ask them what changes would have to happen to improve to a score of eight. These suggestions were then reinforced with the family and they were encouraged to use their own solutions during the week. The miracle question, when asked independently of Katie and her father, elicited a wonderful response. Both of them identified an almost identical miracle of an improved mutual relationship. The impact on Mr. B. was profound when Katie openly and honestly shared her miracle with her father. He appeared surprised and very touched. This seemed to allow him to see the potential in their relationship and seemed to motivate them both to try to achieve their joint "miracle". Again, during each session, I consistently asked "What is different this week? What is better?" Often the family began by saying that absolutely nothing was better. However, by emphasizing exceptions, using scaling and miracle questions the family began to point out small improvements. I used this opportunity to give constant compliments to reinforce the gain they had made in order to help shape their new competence. The most significant improvement seemed to occur between Mr. and Mrs. B. They reported significant changes in their parenting styles that had a direct and positive impact on their marriage. They reported that they were working together

more as a team and felt much more supported by their respective spouse. This may, in fact, explain why the parents reported improvements in their final FAM scores while the adolescent scores did not. Having the parents work more effectively as a team meant that clear and consistent rules and consequences were being implemented more effectively. I hypothesize that this was difficult for the teens to accept because they were used to frequently being able to manipulate one parent against the other in order to get what they wanted.

Structural Family Therapy was utilized in this case as I attempted to restore the hierarchy in the family. After two or three sessions with the family it became clear that their progress was limited. The family members, even the adolescents, kept returning to the fact that there was no real motivation for the teens to listen to or respect their parents. This was due to the fact that they were often able to play one parent against the other. As Tomlinson (1991) warned, this manipulation caused marital friction. Compernolle (1981) argued that problems tend to arise when parental control is inadequate for the developmental stage of the child. This provided me with the rationale that, in order to help this family, this very basic developmental need had to be addressed first. Otherwise, there was too much chaos and unpredictability to support consistent change.

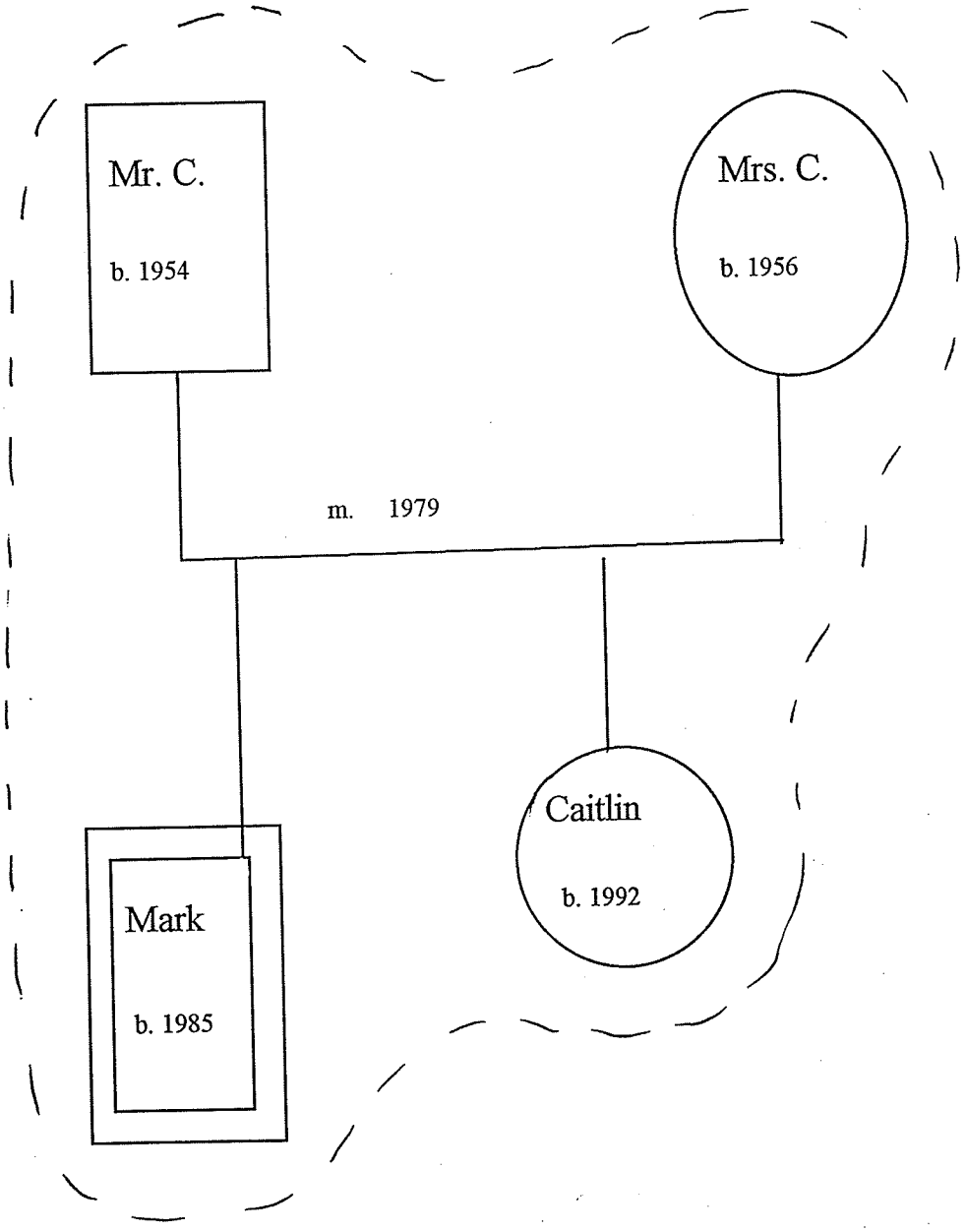
If a "pure" BSFT approach had been used I believe that change in this family would have been limited. This is due to the existing chaos and lack of

true motivation provided within the family. On the other hand, a pure SFT approach may not have been completely successful either. Many of the BSFT techniques provided family members with hope, empowerment, and a way to view their potential as a family more positively. The advantages and limitations of BSFT and SFT are discussed in detail in the next chapter.

In retrospect, there are several things I would have done differently with this case. First, I would not be so preoccupied with being "true" to the BSFT model. I believe that this would have allowed me to be more comfortable implementing the necessary structural change immediately as my instinct dictated instead of waiting for up to three sessions with the family. Secondly, I would ask the parents what they were like as adolescents and try to connect Katie and John and their parents through this technique suggested by Carter and McGoldrick (1989) in order to foster connections between the generations.

The "C" Family - Combined Structural and Brief Solution Focused Family Therapy

Genogram



Background and Referral Information

Mr. and Mrs. C. contacted Kinark Child and Family Services following a discussion with their family physician regarding their frustration and concern about their 12 year old son, Mark. At the point of referral both parents stated concerns about Mark's challenging A.D.H.D. behaviours, low self esteem, sadness and generally negative attitude. Parents stated that they would like to learn how to discipline Mark more effectively, manage his moods and temper and improve his self esteem. Mark stated that he would like to see less fighting and arguing between himself and his parents.

I met with the C. family as a whole, with the parental subsystem and with Mark alone, on an almost weekly basis for a period of three months (six sessions). While the approach with this family was a combination of SFT and BSFT methods, this family was not initially formally designated as one of my practicum families until close to the end of my intervention. Therefore, a pre-test FAM was not administered. However, a FAM was administered two months post intervention. Supervision on this case was equal to that of families formally designated at the first session for the purposes of this practicum.

Initial Interview and Hypothesis

Initial Interview

Mr. and Mrs. C. arrived with both Mark and Caitlin. Caitlin, who is five, was provided with crayons and paper to draw on in the session. During this initial session each family member, in turn, was asked why they came and what they hoped to achieve. Mr. and Mrs. C. immediately identified Mark as their main source of difficulty. Caitlin, listening intently to all of this while curled up on her mother's lap, "volunteered" in the middle of her mother's response that Mark was "mean to her". The parents' initial attitude toward Mark was quite negative and the parents appeared frustrated and confused repeatedly asking, "Why does he do these things?" They were particularly upset about his temper outbursts (yelling, screaming, stomping, destroying objects), his refusal to comply with their directions, and his lack of self-esteem. In short, Mark was identified as the "symptom bearer" in this family by all family members. When Mark was not "acting out" his parents described him as being sad, quiet, withdrawn and irritable. When the parents had finished they were reminded of the second part of the question: What do you hope to accomplish or achieve by coming here?" Both parents agreed that they wanted to be able to discipline Mark better, manage his mood swings and temper more effectively and help to improve his

self-esteem. In addition, Mrs. C. stated that she wanted to be able to assert her authority with Mark more effectively. She stated that Caitlin "was no trouble" but then qualified this statement by saying that she was still young and easier to manage.

Mark was then given the opportunity to respond. He stated that he came because his parents told him he had to and because he's tired of his parents always fighting with him. Mark stated that he wanted the fighting to stop.

Throughout this interview Caitlin moved from one parent to another to "cuddle" and persistently, and successfully, interrupted Mrs. C. more often as the meeting progressed, despite Mrs. C. pleading with Caitlin to sit still, etc. Mrs. C. would periodically glance at Mr. C. for help and he would then say firmly to Caitlin "sit still" (or "color in your book" etc.) and she would listen for awhile until the pattern was repeated. Mark listened quietly, at first, and made little eye contact with anyone. He yawned and stretched frequently during his parents response indicating boredom with their answers. I attempted to shift the negative atmosphere into the positive by asking about Mark's strengths. Many of the answers came back with a "negative connotation" to them which I attempted to reframe in a more normalized (age appropriate) and positive and humorous light. For example, the parents appeared extremely frustrated by the fact that Mark had to be reminded regularly to "scoop the dog poop" from the driveway. To de-escalate some of the excessive frustration shown in this situation and to

attempt to join better with Mark, I commiserated with him over the unpleasantness of such a task and asked him if he had to wear a "gas mask" or did he just run from "one poop to another" - and some other humorous "technical" questions. Mark seemed to enjoy this positive attention and readily shared the "gory details". In the end I complemented Mark on his strategies because it was apparent that when he did do this task he was very thorough and he did a good job of a rather unpleasant task. We concluded that he just needed to do it more often. Parents joined in on the humour and agreed that the situation wasn't "all bad". I then, again, encouraged parents and Mark to highlight his other strengths. The parents seemed to have a slightly easier time identifying some of his strengths at this point but still seemed invested in maintaining Mark as their scapegoat.

Hypothesis

I hypothesized that Mark had become the scapegoat for this family's dissatisfaction and conflict. However, I also hypothesized that the stress this family was experiencing was primarily due to external factors (limited finances, conflicting work schedules, minimal time for parents to be a "couple" or have time alone, etc.) that were exacerbated by the challenging

behaviours of an A.D.H.D. (pre) adolescent that they did not understand causing parental exhaustion, overload and frustration. The marital subsystem appeared quite strong and supportive so I did not see Mark serving to detour their conflict. However, I was concerned with some boundary issues particularly between Mrs. C. and the children.

I also hypothesized that Mark's low self-esteem was directly related to the parents' perception of Mark's (A.D.H.D. and adolescent) behaviours and consequent level of frustration with him.

I further hypothesized that Mrs. C's exhaustion was related to ineffective boundaries with her children, in addition to the external stressors identified.

Therapeutic Goals

1) To help improve Mark's self esteem and self image by advocating for the following actions:

a) parents agreed to give Mark "positives" every day and to find some behaviour that could be acknowledged. This action was promoted regularly in sessions through modeling and family discussion. It had the benefit of helping to improve Mark's self esteem and mood as well as helping parents to move out of their habit of negative perception and frustration with Mark.

b) to help parents identify reasonable expectations for Mark - given his disability of A.D.H.D. I hypothesized that reasonable expectations would help to lessen parental frustration and increase the positive perceptions and interactions between parents and Mark.

2) Parents to set reasonable expectations, limitations and consequences for Mark through the following actions:

a) education and information on ADHD materials were provided and parents were encouraged to do some research on their own also

b) emphasis on discussing behavioural strategies and interventions during family meetings with particular emphasis on what strategies are currently effective

c) parents to attempt to work as a team and have the same expectations and enforce the same logical consequences whether there is one parent present or two.

Course of Therapy

I combined SFT and BSFT in the following manner: the SFT method was used to "map" the family dynamics and help me to pinpoint areas of strength (e.g., marital subsystem) and those that required intervention (e.g., boundaries between Mrs. C. and children). The families' assumptions were primarily challenged through teaching them information about adolescence and ADHD as well as using the "stroke and kick" method of SFT. Minuchin (1974) described his "stroke and kick" method as being useful in strengthening boundaries between subsystems. When using this technique the therapist compliments (strokes) the client and then immediately puts a negative connotation on it (kick). For example, in this family I would often say to Mark "Look at how much your mother cares for you. She wants to help you out when you are floundering for an answer to one of my hard questions. She doesn't want you to have to struggle (stroke). She takes your voice away though doesn't she?" (kick). Shaping competence through compliments and repetition was also useful in this family. Similarly, highlighting interactions and unbalancing were also useful in modifying family interactions. Enactment, modeling and role play were utilized thoroughly within sessions. The BSFT method was used to help the family construct solutions and to identify areas that were already successful (which

were then practiced in session). In addition, the BSFT approach was helpful in giving the family more control over their goals and solutions fostering a greater sense of mastery. The initial goal was to join with the family and establish rapport with each member. This technique had to be repeated frequently with Mark throughout all sessions. Some of the methods that worked particularly well with him included emphasizing his strengths, normalizing some of his behaviours to his parents, focusing on shifting negative parental perceptions and engaging him in solution talk which helped him feel more "equal" as a participant.

For the next five sessions I met with the family together and with different subsystems within the family. As the sessions progressed there was an increasing shift to BSFT asking the family, "How do you want to spend our time together today? What would be most beneficial to you?" while using many of the SFT techniques such as role play and practice.

During the second and third sessions I emphasized the importance of reasonable expectations of Mark and focused on challenging and reframing the negative attitude parents had toward him. Each session included time for highlighting Mark's strengths. In addition, I encouraged, supported and modelled for Mrs. C. how to give directions to Caitlin and Mark so that the directions were followed. I spent time with Mr. and Mrs. C. alone at the end emphasizing their role as a team when parenting and disciplining each of the children. We discussed how they could support each other in this and they

began identifying consistent rules and methods of intervention that they believed would work.

Sessions four, five, and six were primarily spent generating solutions and reinforcing solutions that were already effective. By this point, parents were finding it much easier to understand many of Mark's behaviours in terms of ADHD and (pre) adolescence which helped to limit their frustration and negative perspective of him. Consequently, the family began reporting more positive and less confrontational interactions. Mark also became more involved in the sessions and parents reported that his moods had improved. During the last session, I did some final scaling questions with this family. Mr. C's report of arguing went from an 8 to a 3, Mrs. C's went from an 8 to a 5 and Mark's went from a 10 to a 5. Regarding self esteem, parents estimated that Mark had improved from a 2 to a 7 and Mark reported a change from 5 to 7 (all scaling was completed on a 0 to 10 basis).

Discussion of Measures (FAM and Client Satisfaction)

FAM

The post-intervention FAM's (see Tables #7, #8, and #9, Appendix A) indicated that all family members saw their family as being quite healthy in

the average range on most of the subscales. Mr. C. (see Table #8, Appendix A) was slightly elevated (scoring 64) which indicates perceived problems with task accomplishment, affective expression and involvement. Mrs. C. (see Table #9, Appendix A) was slightly elevated (scoring 66) on task accomplishment and control. Mark scored well within the average range in each area (see Table #7, Appendix A). It is not possible to compare pre and post measures in this family. However, the scores seem to support the family's report of their satisfaction with most of the changes they were able to effect. One exception to this is represented by Mr. and Mrs. C's task accomplishment scores which remained in the problem range. I interpret this finding as indicating that both parents still have concerns about how capable the family is at problem solving.

Client Satisfaction Questionnaires

Client Satisfaction Questionnaires (see Appendix B) indicated an overall "very good" rating. Most individual questions were either rated as "strongly agree (1)" or "agree (2)" except for the question, "Did you receive enough service" which was rated as "not sure (3)". I called the C. family two months following service and asked if they required a "booster" session or two and they declined at this time stating that "things were going well".

Discussion

A combination of SFT and BSFT was used for this family. I found that SFT was most useful initially. Structural Family Therapy's greatest offering was in providing me with a structural map of the family to base my hypothesis on. Once this "map" was in place it became easier to identify the patterns of family interactions that were causing problems and to choose an appropriate intervention. For example, issues of boundary (enmeshment) and hierarchy became obvious when I observed the interactions between Mrs. C. and her children. Mrs. C. would allow her children to constantly interrupt her and tended to plead with them instead of giving them clear directions and consequences. In addition, Mrs. C. seemed to rely excessively on Mr. C. to "rescue her" and enforce her directions to the children. Given these interaction I hypothesized that it was important to strengthen Mrs. C's role in the parental subsystem which would also restore the hierarchical balance in the family and clarify the boundaries between the parental and sibling subsystem.

With the SFT model I had the freedom to intervene in order to attempt to change the structure of this family. I also had the freedom to teach and advise. I found this particularly useful for providing parents with information regarding ADHD. I had been previously employed as a

multi-disciplinary Team Leader for an ADHD program and consequently had a number of resources and information to share with them.

Structural Family Therapy intervention with this family also had its drawbacks. For example, I noticed a tendency for this family to become frustrated with the pathology orientation and past tense emphasis of this model. As I, during one session in particular, focused on Mrs. C's interactions with the children, she burst into tears stating that "Everything is my (her) fault". This outburst may have been the result of several factors including Mrs. C's low self-esteem and my own clumsy attempts at working with a new (to me) model. It can not be overlooked, however, that the SFT model has an innate tendency toward pathology that can be noticed by the client. This was a "turning point" for me in the course of therapy. It was at this point that I began to focus more on BSFT which provided this family with a welcome shift into a more positive, future and solution oriented approach.

At this point in the therapy I began implementing BSFT guided by my structural map of the family. We began to focus on finding solutions to their arguing. Exception finding questions were particularly helpful for this family. Mrs. and Mr. C. tended to get "stuck" viewing Mark's behaviour as negative and pervasive. Exception finding questions helped to eventually lessen this tendency and instill a more hopeful and positive outlook in the

parents. I also believe that Mrs. C. found the coping questions helpful. I think that her own self-esteem and confidence in dealing with the children, and particularly a challenging adolescent, was raised when I showed my admiration of her efforts by asking such questions as "You are often left alone to deal with both children. It must be exhausting. How do you manage?" I would then use her answer (for example "I give them 'the look' and they know they have to do as they are told") to praise her strength and effectiveness as a parent to encourage her to use this effect strategy more often.

CHAPTER 6: ATTAINMENT OF LEARNING GOALS AND CONCLUSION

It is my opinion that all learning objectives were met. A thorough knowledge of Structural Family Therapy, Brief Solution Focused Therapy, and the nature of parent-teen conflict was developed from the existing literature; a newly acquired skill level was achieved using these frameworks as methods of intervening with families experiencing parent-teen conflict, and; perhaps most importantly of all, I greatly increased my confidence in assuming the role of therapist. Several areas of insight and learning are particularly vivid for me. Firstly, I discovered the powerful role that empathy can play in intervention. I found it very useful, at times during the course of therapy, to have family members attempt to "tune in" to a particular family member. I found that this was most useful when the family seemed "stuck" on scapegoating a single family member. At this point I encouraged the family members to attempt to see things from the "identified patient's" point of view. I also asked them to explore the stressors in that person's life in order to better understand their behaviours and feelings. This seemed to help break the existing cycle of negativity. This exercise in empathy seemed to allow family members to connect or reconnect with each other and more positive interactions were often fostered as a result. For

example, Mr. and Mrs. B. were initially focused on Katie's "purposefully bad" behaviour. When we explored the significant stressors in Katie's life I could feel parents shift to feeling compassion for their daughter. Mr. B. even said, albeit jokingly, "It's surprising that (due to all of the stressors in her life) she's not worse than she already is". Parents were able to view Katie's behaviour in a less threatening manner. As they viewed her behaviour differently they were "freed up" to put more energy into solutions instead of being so invested in blaming. Secondly, I found the skill of complementarity to be a very powerful tool for family members. I found that complementarity fosters a positive sense of teamwork and support. This is particularly empowering for parents who may be experiencing the exhausting effects of the stress of raising a difficult adolescent that Tomlinson (1991) refers to. Knowing that your partner will help support you in areas that you are weak in, and vice versa, often gives parents the confidence and energy necessary to deal more effectively with their adolescent. Third, I came to believe that Schulman's (1992) basic "skills of helping" must be present in every Social Worker's approach in order to make any model of intervention effective. Many of these basic skills focus on communicating with one's client, tuning in to one's self and client and responding effectively. Schulman emphasizes the importance of such skills as elaborating, responding with empathy, sharing feelings, identifying obstacles and making connections. He also covers skills specific to each phase of therapy. I would argue that any model

of intervention is only as successful as the therapist's use of self and their use of these basic skills. Without these basic skills any model of intervention is severely limited in its effectiveness. A fourth aspect of importance that I discovered while working with these families the usefulness of knowing behavioural modification theories. These techniques and theories helped me, as a therapist, to be able to identify patterns of interaction and to be able to theorize why particular behaviours continued to occur. For example, once I had identified a pattern of stimulus and response (e.g., Katie goes out of her way to enrage her father with her behaviour). I would look to understand what the positive or negative reinforcing factors were (e.g., She gets his undivided attention even though it is negative attention). It was at this point that I could make a hypothesis (e.g., Katie is desperate for any kind of attention from her father). With a working hypothesis available it was easier for me to generate logical intervention techniques (e.g., focus on having Katie seek positive attention). Finally, I also learned the importance of trusting my own instincts and allowing myself to integrate models instead of feeling confined or limited by the parameters of one model. In retrospect there were several situations where I know it would have been more beneficial to the client if I felt able to draw on skills and knowledge from my own past experience instead of being overly focused on adhering strictly to the model. For example, I found it very useful to be able to use SFT to initially understand the structure of a family and its interactions while some of the

specific techniques of BSFT generated a more positive approach to problem solving.

Central to the investigation of parent-adolescent conflict is the concept that conflict can either be constructive or destructive. Conflict, in itself, is not necessarily negative (or positive). In fact, according to Deutsch (1973) conflict is important because it demarcates groups from one another and therefore helps group and personal identities to form. According to Erkison (1968) conflict is significant in adolescence as the primary developmental task is for the adolescent to establish an independent personal identify from their parents. As adolescents become independent from their parents the potential for conflict increases. Conflict that is handled in a constructive manner can foster growth and identity. I attempted to help these families see that conflict is part of the developmental growth of the adolescent and that they could really contribute to their adolescent's growth by fostering positive conflict resolution. This helped parents to see that the conflict they were experiencing actually had a purpose. I believe that the key to remember when dealing with parents and adolescents in conflict is not to attempt to eradicate the conflict but to help both parties to enter into the process of constructive conflict by learning skills in communication and negotiation.

This particular practicum experience taught me that regardless of approach, there are several other "rules of thumb" that were useful to me. First, it is important for parents to be the "head" of their family by providing

adequate parental control. This is supported by Compernolle (1981) who stated that adolescents benefit emotionally from adequate parental control. Second, it is important for parents to "pick and choose their battles". As Pittman (1987) stated, "parents must provide expertise on matters of substance". Otherwise there are too many issues to argue about and become embroiled in. I recommended that parent try to ignore issues that were not related to health, safety and morality. For example, I argued that it was better to ignore an adolescent's messy room by closing the door then to waste precious energy that may be needed to confront moral or safety issues that are more crucial. A third key was to encourage parental flexibility and communication between all family members. Parents need to know that adolescents need to have input in some, but not all, decision making processes. Given the above identified approaches for families and adolescents I believe that 6-8 focussed sessions, regardless of approach (SFT or BSFT) should be adequate.

Working with families with ADHD adolescents brings its own set of unique challenges. These adolescents, as their disorder suggest, have difficulty paying attention. This creates issues in sessions as well as at home. In session, I made conscious efforts to ensure eye contact with the adolescent when I was either addressing him specifically or attempting to highlight something important. Similarly, I often repeated key points when I did have their attention to ensure that they received the information. Another strategy

that was helpful was to shorten the length of the session. I would often spend half of the session with the entire family and then give the adolescent a "break" while I met with the parental subsystem. Other times I met one on one with the adolescent which was less distracting for him. ADHD also poses issues regarding interventions at home. I helped parents use the same techniques described above to discuss issues with their adolescents or to give instruction. Another key issue with ADHD children is impulsivity (DSM-IV). An ADHD child will act without thinking, often with disastrous consequences. Once again, it was important to help parents see some of the actions of their adolescents as impulses due to a deficit in attention not due to a lack of respect or intention to be difficult. This approach helped parents view their child as having a deficit in attention instead of labeling and viewing them as "bad".

The Structural Family Therapy model taught me several useful strategies in my practicum experience. I found the SFT model extremely helpful in initially conceptualizing family organization and understanding its structure. This, in turn, helped me to more easily generate workable hypotheses and identify potential areas for intervention. While a major criticism of the model itself is that it tends to be pathology or problem oriented it can still promote many positive forms of intervention. For example, I found that the perspective of viewing issues as part of an entire system, versus identifying

one "patient", was extremely impactful on families. I found this to be particularly true when I saw that many of the families I worked with immediately identified their adolescent member as the sole symptom bearer in the family. Challenging this belief allowed me to better join with the adolescent member who often tended, naturally, to be initially quite defensive and limited in their participation in therapy. This "joining" with the adolescent was only used when the scales between the parent and adolescent were quite unbalanced. Similarly, I would "join" with the parents regarding other issues, particularly pertaining to rules for the adolescent's health and safety. Throughout the rest of the course of therapy I attempted to maintain a neutral position. Another method that I found particularly useful when working with these families was the use of complementarity. When following the perspective of family interactions (versus identified patient) maintaining the "problem" in the family the use of complementarity can be a useful tool for intervention. In this situation emphasizing the need for the parents to work together as a team with the goal of providing consistent rules and consequences promoted the sense that many of the changes need to be shared between family members. It also helped de-emphasize the original scapegoating of a single member of the family. As I mentioned previously, once this pressure is alleviated from the adolescent and adequate joining is implemented the adolescent seems to engage much more actively in therapy resulting in an overall benefit for the entire family.

Many of the parents and family members were initially reluctant to view the "problem" in any other way except as a fault of the adolescent. Two other methods that I found particularly helpful were Minuchin's (1974) "stroke and kick" technique and facilitating change through challenge. Throughout this entire process it quickly became apparent to me how essential it is to first have adequate joining and accommodation with each family member. This joining technique must be monitored closely throughout the course of therapy and repeated as necessary.

Similarly, the Brief Solution Focused Therapy method provided many practical gains for me. I found that many of the families seemed to appreciate the sense of control over their therapy. This sense of control was facilitated by finding out what the clients want versus what they don't want and by helping them with their own resolutions. In addition, a great sense of hope seemed to be evident in many of the BSFT families. Finding exceptions seemed to promote a greater sense of control and hope in the families. Once an exception was identified the family members seemed to be able to view the issue as less pervasive. Scaling questions helped families to see the importance of small changes. They learned that small change can gradually, or quickly, lead to greater changes facilitating more hope and a sense of mastery and progress and control. The strength oriented philosophy of BSFT allows many clients to experience positive overall perspective changes through the use of solution language and the emphasis on finding unique and

individual solutions. I also found that, while many therapists seem skeptical about the miracle question it can be an effective way of helping clients to define their goals and to visualize and verbally share with other family members their intimate wishes. Framing one's language so that it is solution oriented and stating what the client wants versus doesn't want (e.g., "It would make me feel wonderful if you were to smile at me when you come home from school" versus "You are always so negative when you come home from school") helps other family members to "hear" and accept what is being asked of them. It appears as though this approach helps to lessen defensive barriers in the communication process and thereby facilitates change.

Integrating the SFT and BSFT models of family therapy was beneficial in many ways. I tended to first view the family from a structural viewpoint in order to hypothesize about areas for intervention and attempt to diagnose the family as a structure. From this point, both models emphasize the importance of joining and accommodating a family at first contact and all throughout the sessions. For very obvious boundary and subsystem concerns many of the SFT techniques such as the "stroke and kick", unbalancing, challenging assumptions, complementarity, highlighting and modifying interactions, use of intensity and role play (etc.) were used. From this point I tended to begin to incorporate more of the BSFT type questioning: coping questions, miracle questions, exception questions, scaling questions, and pre

or between session change questions in order to introduce more hope and sense of control in the family system.

Structural Family Therapy and BSFT differed in many areas. The first area of difference lies in each model's respective philosophy and goal. In SFT the goal is to transform the family structure in dysfunctional areas. It is a pathology or problem oriented philosophy. The goal of the BSFT model, on the other hand, is to help clients define goals and construct their own solutions. It is a very future and strength oriented philosophy and model. The role of the therapist also differs between the models. In SFT the therapist is seen as a leader and agent of change. In the BSFT model the therapist facilitates clients with their own solutions. The models differ in how clients are viewed. In SFT the clients are viewed in the context of the structure of the family. For example, which subsystem they belong to, what their place in the family hierarchy is (or should be), whom do they interact with and how. In the BSFT model, according to Duvall (1994), clients are either viewed as a consumer (someone who will commit to and participate in service), a visitor (someone who is often referred by a third party and who tend not to be interested in service), or a complainant (someone who is only interested in service during a crisis). The beginning phase of each of the models emphasizes the importance of joining with the client. However, from this point on in therapy the direction changes. Structural Family Therapists

become more interested in working with interactions and diagnosing whereas BSF Therapists focus on exploring present and past exceptions and solutions.

This practicum provided me with many areas of personal change and growth. As a family therapist I learned about many of my strengths. For example, I believe that I have a good ability to join quickly and solidly with clients. I learned not to become overly anxious with clients who showed great anger in sessions with each other or who challenged me. I gradually learned to welcome these interactions as a powerful opportunity for intervention. When it was me who was being challenged I tried to make it an opportunity to really connect with clients and to learn to hear what they were saying. I also learned that I have a good deal of experience to draw upon from my past work placements and gradually found it easier to integrate these experiences into the models I was using. As a beginning therapist I still need to continue building my confidence with experience. I also find that I have a tendency toward a psycho-educational approach. I tend to prefer to "teach" strategies and give information. I need to be constantly aware of this in order to balance my approach with clients. In addition, I find myself still wanting to have answers and expertise for my clients and I need to balance my anxiety of providing this with the actual needs of the client. Of course, I still need more experience with both of these models to become even more natural and proficient in using them.

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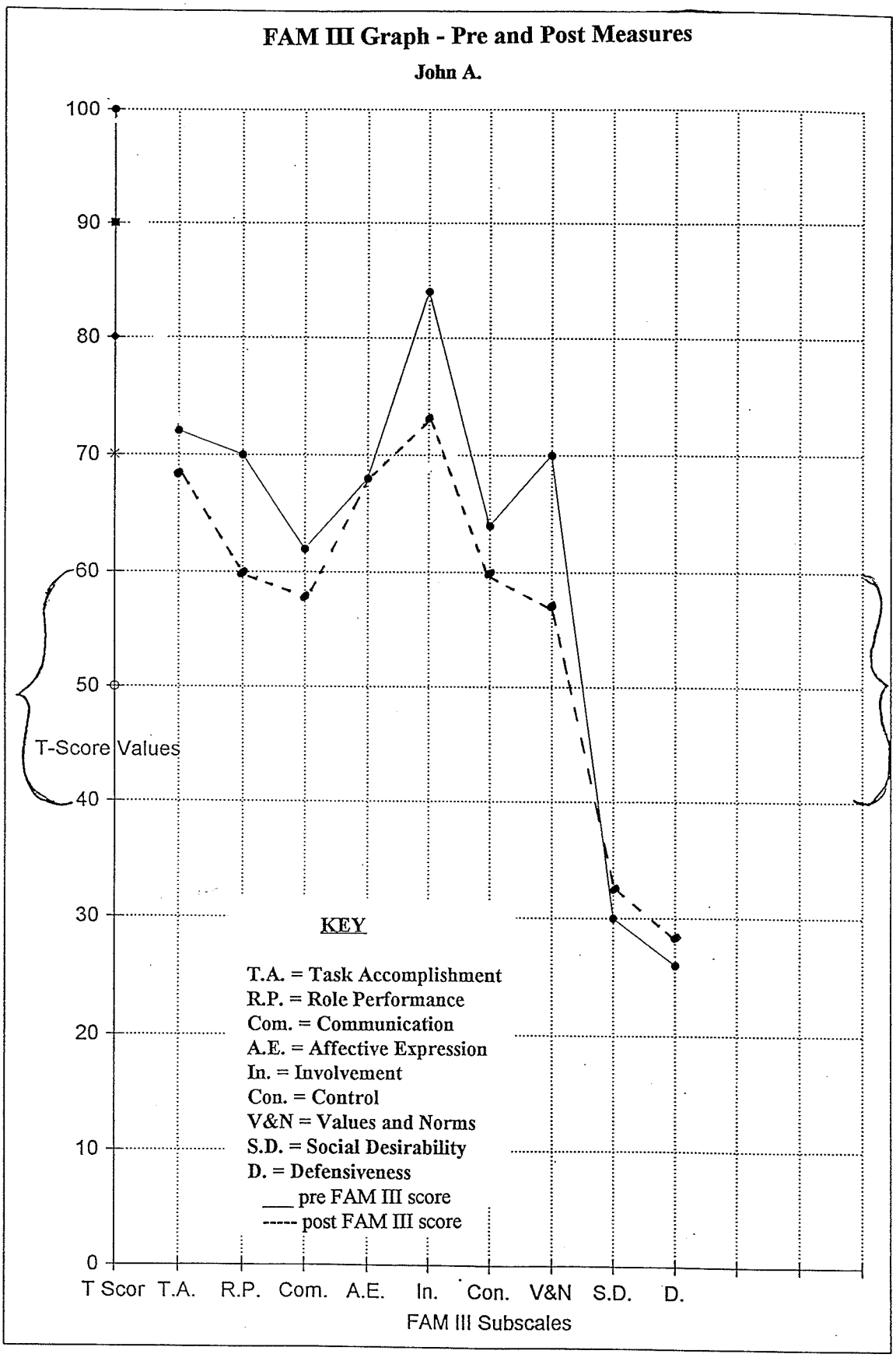
APPENDIX "A"

TABLE #1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T-Score Values
Family Problem
Average Range
Family Strength
KEY
T.A. = Task Accomplishment
R.P. = Role Performance
Com. = Communication
A.E. = Affective Expression
In. = Involvement
Con. = Control
V&N = Values and Norms
S.D. = Social Desirability
D. = Defensiveness
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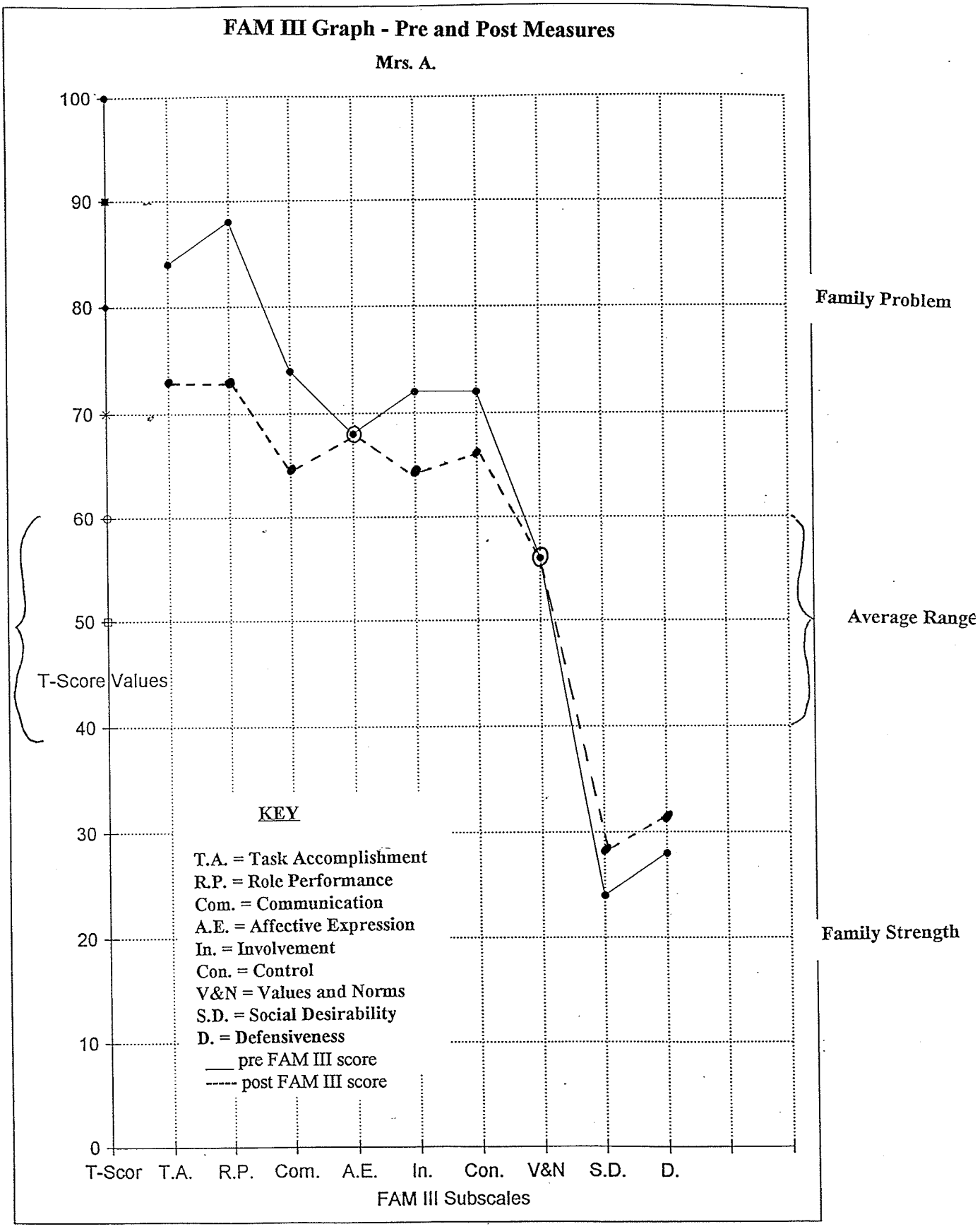
FAM III Subscales

TABLE #2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Family Problem
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Family Strength
KEY
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R.P. = Role Performance
Com. = Communication
A.E. = Affective Expression
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Con. = Control
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S.D. = Social Desirability
D. = Defensiveness
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FAM III Subscales

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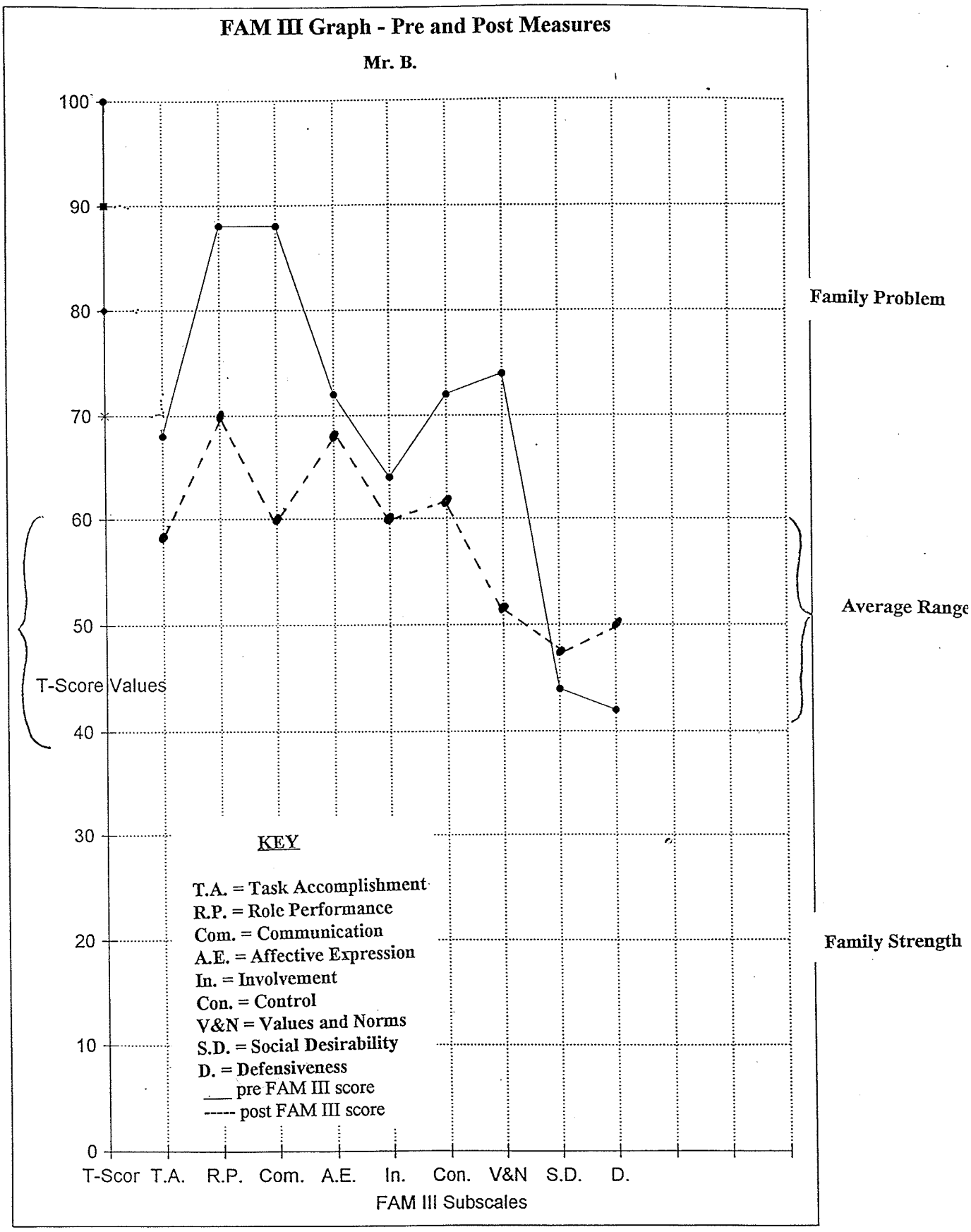
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R.P. = Role Performance
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A.E. = Affective Expression
In. = Involvement
Con. = Control
V&N = Values and Norms
S.D. = Social Desirability
D. = Defensiveness
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FAM III Subscales

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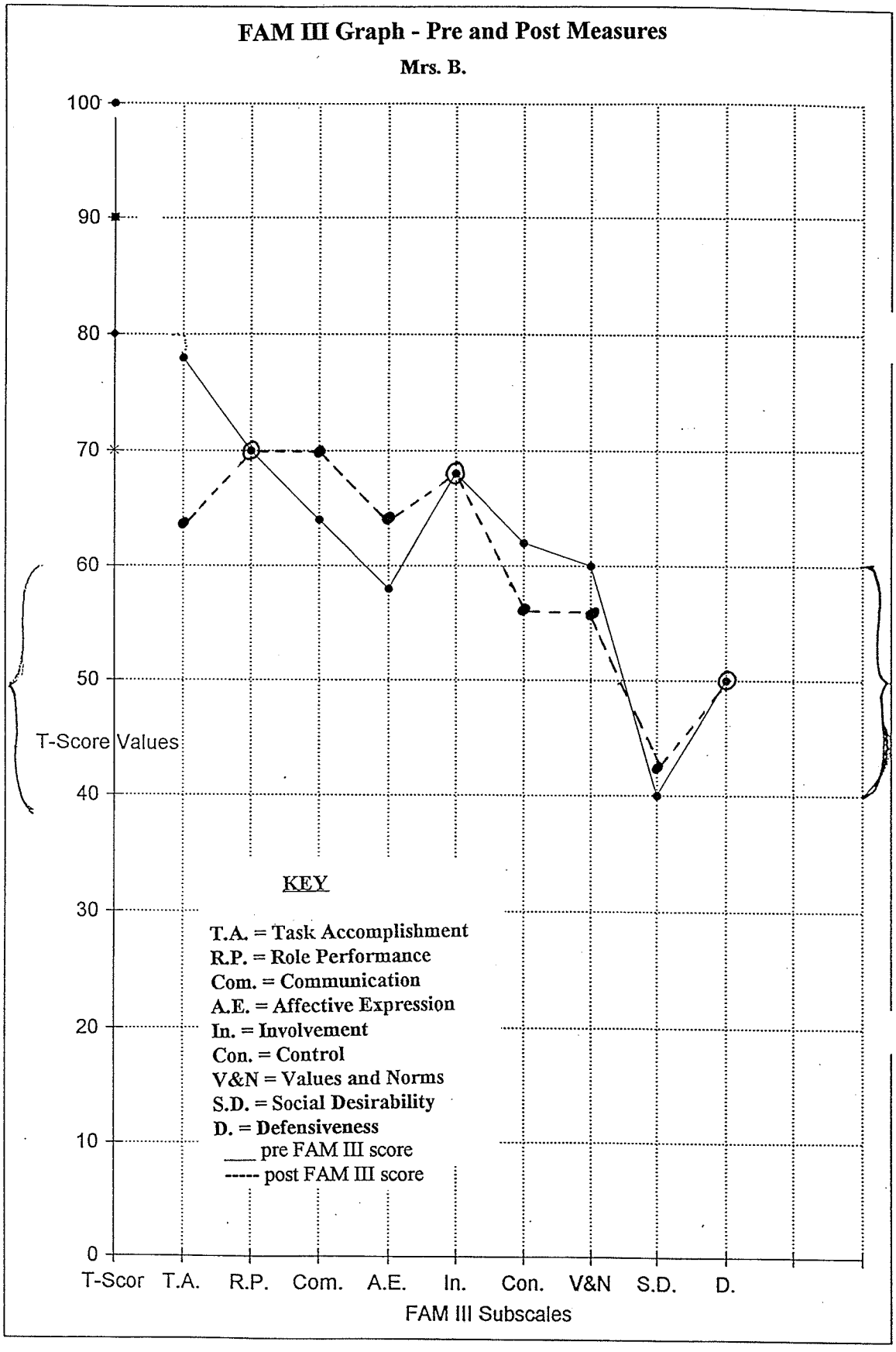
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A.E. = Affective Expression
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V&N = Values and Norms
S.D. = Social Desirability
D. = Defensiveness
___ pre FAM III score
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T-Scor
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FAM III Subscales

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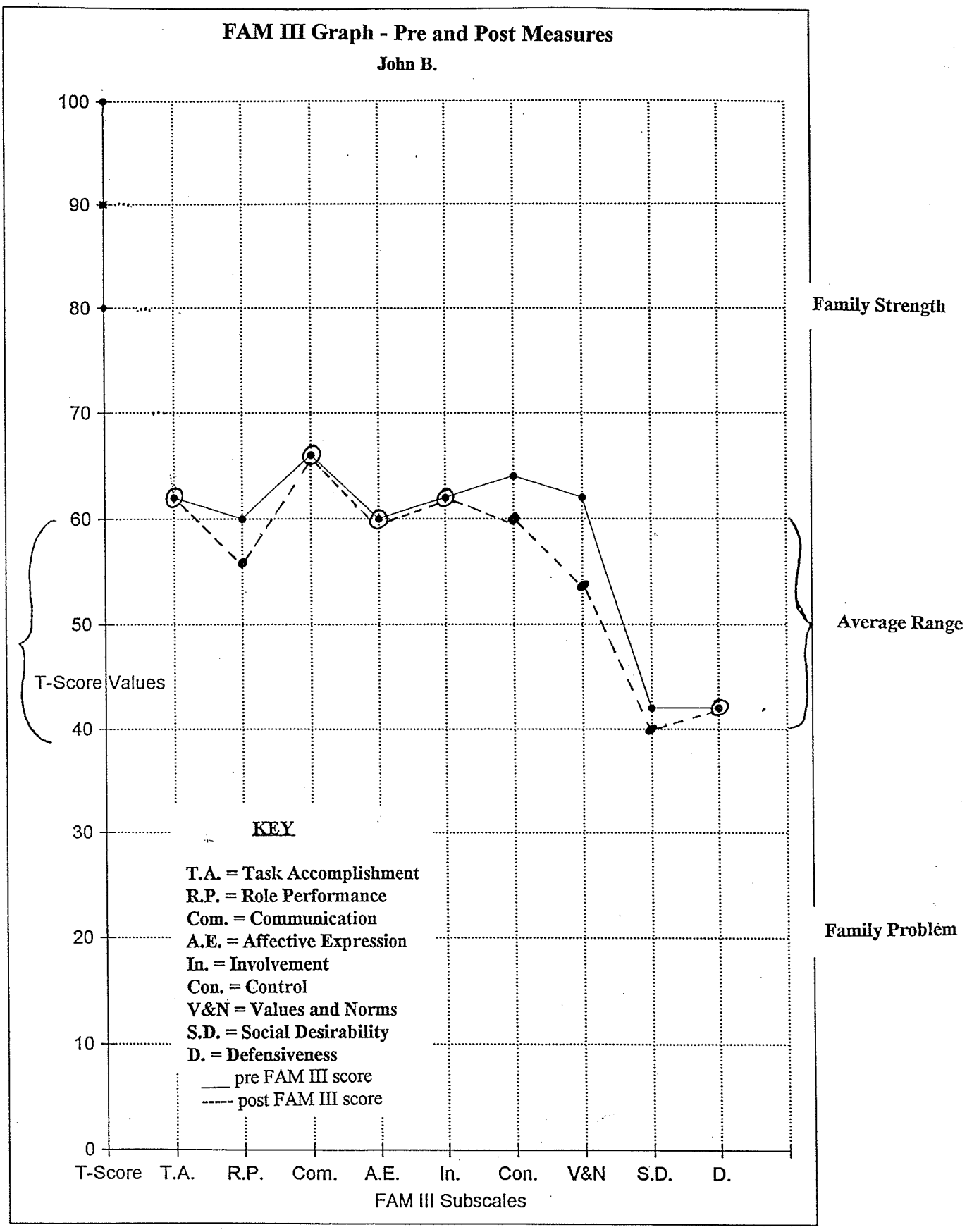
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In. = Involvement
Con. = Control
V&N = Values and Norms
S.D. = Social Desirability
D. = Defensiveness
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----- post FAM III score
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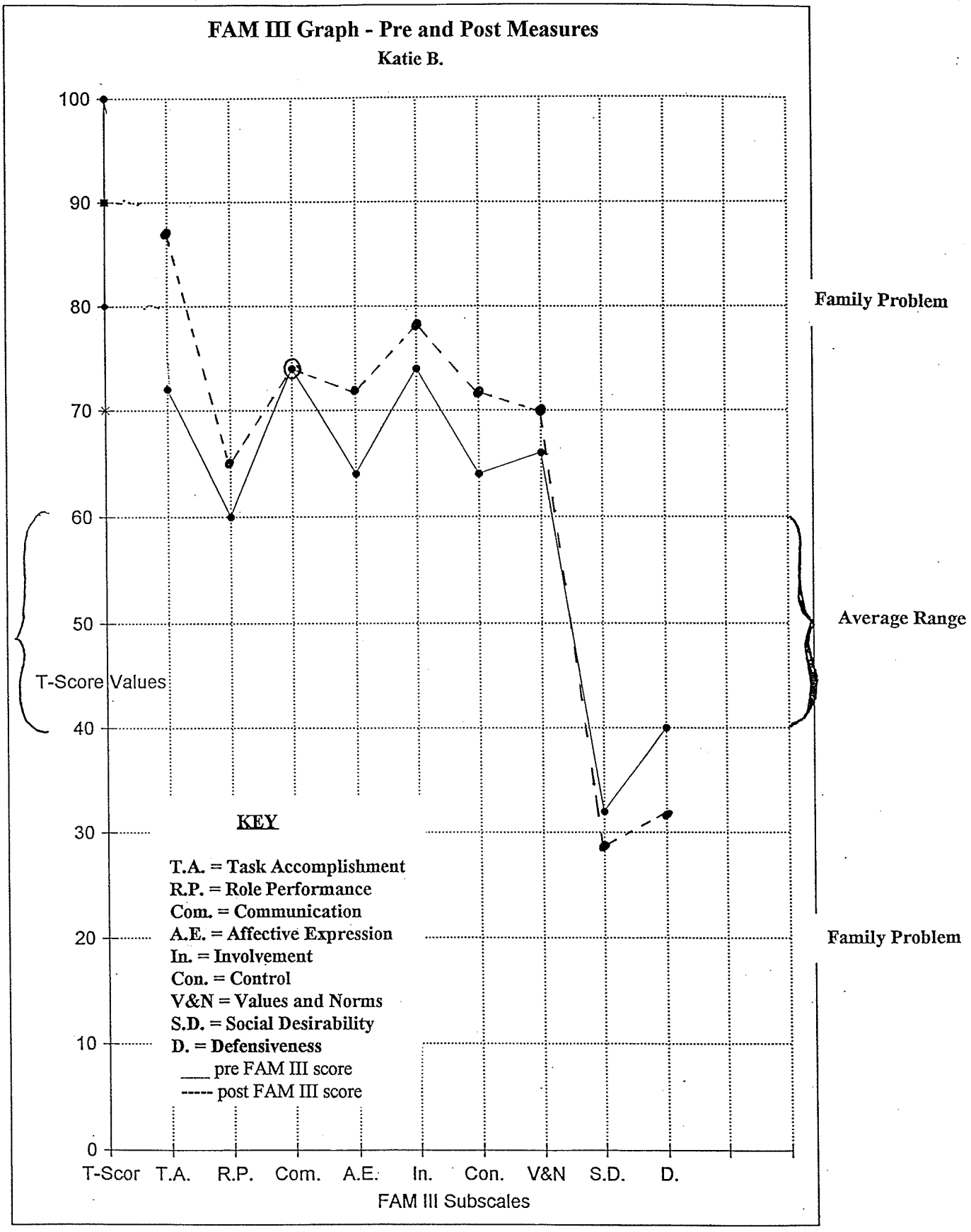
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Com. = Communication
A.E. = Affective Expression
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Con. = Control
V&N = Values and Norms
S.D. = Social Desirability
D. = Defensiveness
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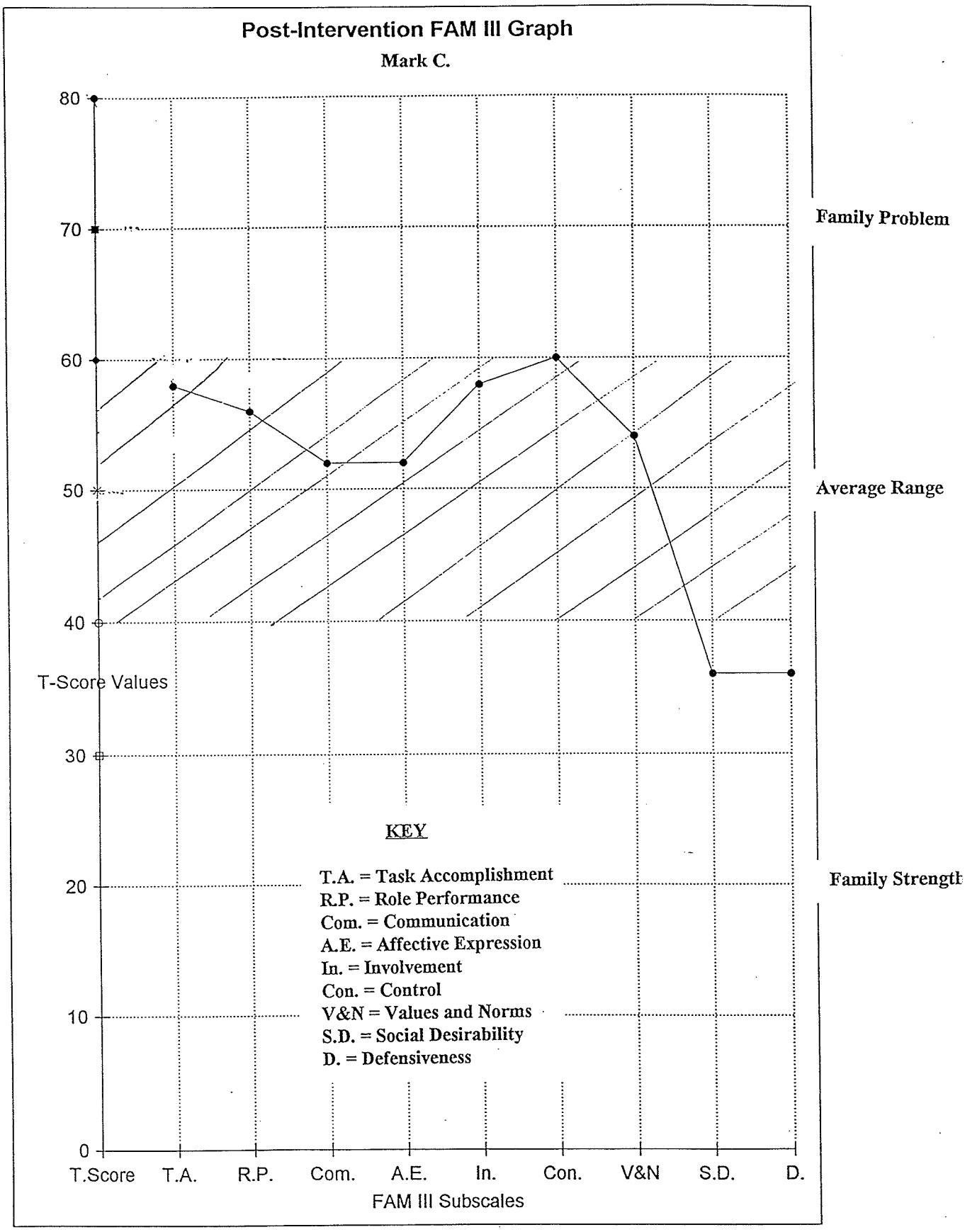
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A.E. = Affective Expression
In. = Involvement
Con. = Control
V&N = Values and Norms
S.D. = Social Desirability
D. = Defensiveness
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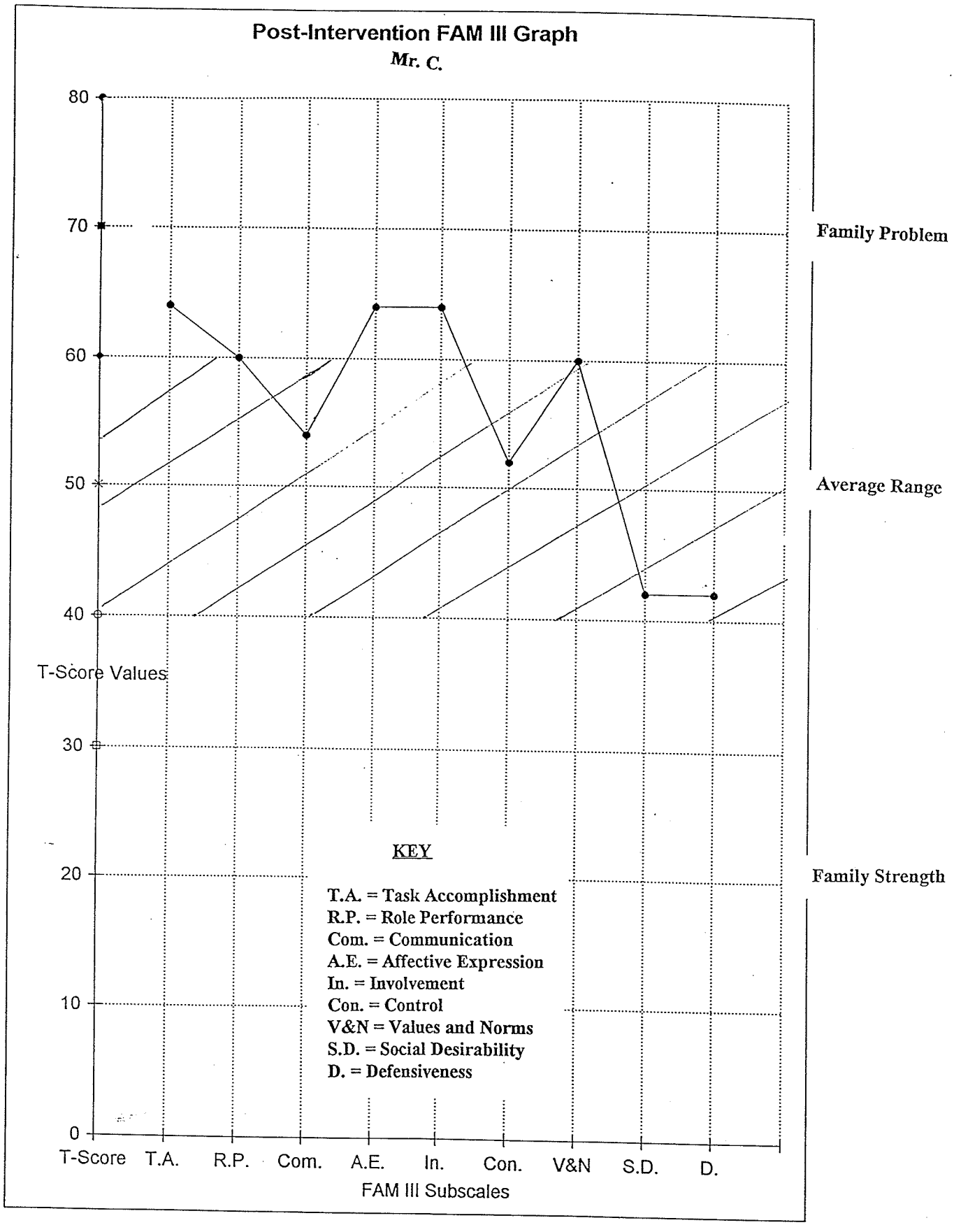
Post-Intervention FAM III Graph
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T-Score Values
Family Problem
Average Range
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In. = Involvement
Con. = Control
V&N = Values and Norms
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T-Score
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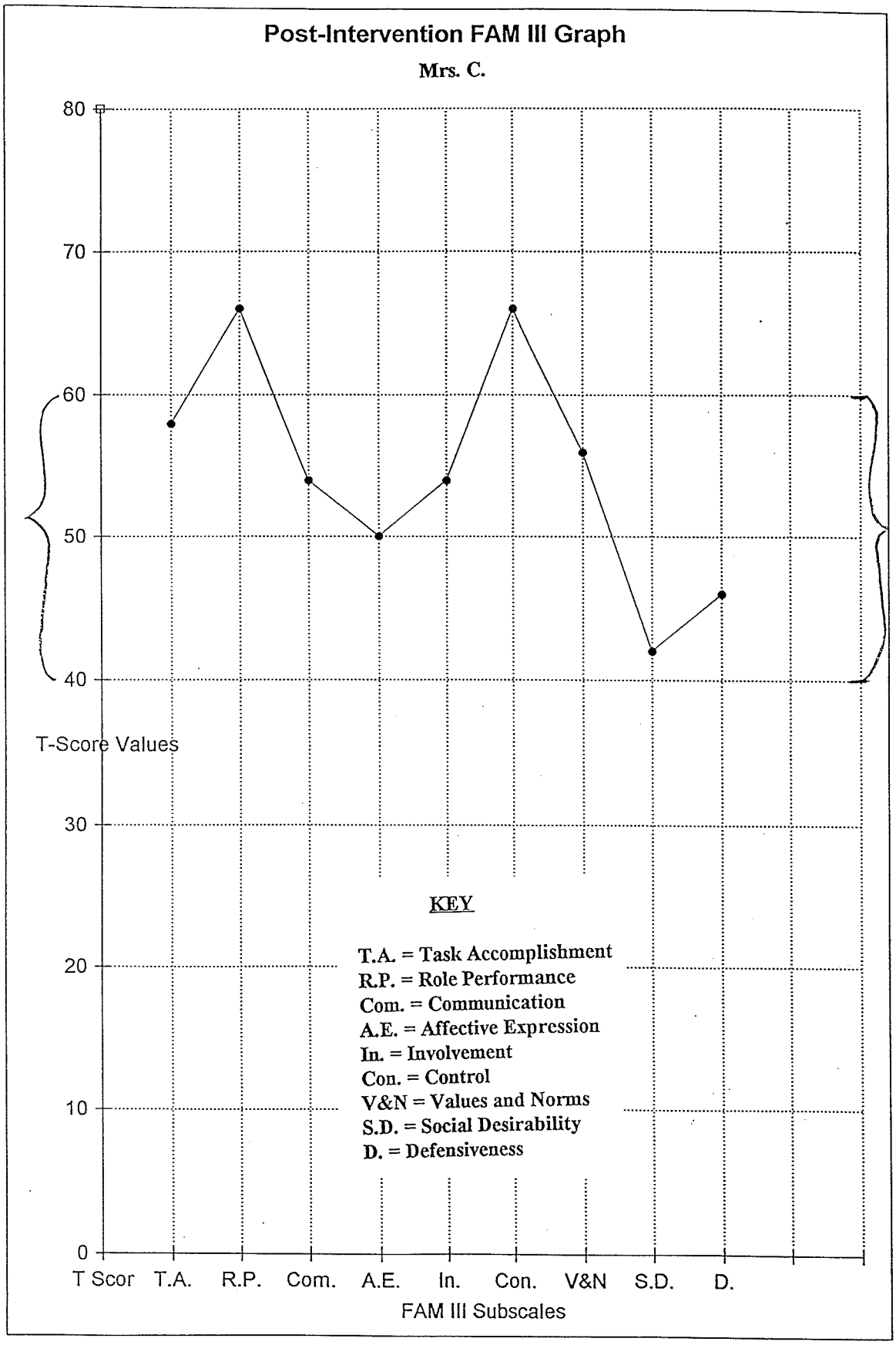
S.D.
D.
FAM III Subscales

TABLE #9


Post-Intervention FAM III Graph
Mrs. C.
80
70
60
50
40
30
20
10
0
T-Score Values
Family Problem
Average Range
Family Strength
KEY
T.A. = Task Accomplishment
R.P. = Role Performance
Com. = Communication
A.E. = Affective Expression
In. = Involvement
Con. = Control
V&N = Values and Norms
S.D. = Social Desirability
D. = Defensiveness
T Scor
T.A.
R.P.
Com.
A.E.
In.
Con.
V&N
S.D.
D.
FAM III Subscales

APPENDIX "B"

KINARK CHILD AND FAMILY SERVICES

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: John A.

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: X

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: _____

I DO NOT WISH TO COMPLETE THIS FORM: _____

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1	2	3	4	5
Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	(1) 2 3 4 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	(1) 2 3 4 5
3. I was encouraged to express my vies about what would be helpful for me and my family.	(1) 2 3 4 5
4. Meetings were planned at times and places that were good for my family.	1 (2) 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	(1) 2 3 4 5
6. I was satisfied with the role I played in developing the plan of services for my family.	1 (2) 3 4 5
7. The services I received at Kinark helped.	1 (2) 3 4 5
8. I received enough service.	1 (2) 3 4 5
9. I would recommend Kinark to others or use it again for my family	1 (2) 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

1	2	3	4	5
(Very Good)	Good	Neither Good Nor Poor	Poor	Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

- less fighting now
- we do more together
- less drinking

If I could change one thing about Kinark, it would be:

Any other comments or suggestions?

Thank you for your help!

KINARK CHILD AND FAMILY SERVICES

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: JOHN A (MRS. A)

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: ✓

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: _____

I DO NOT WISH TO COMPLETE THIS FORM: _____

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1 Strongly Agree | 2 Agree | 3 Not Sure | 4 Disagree | 5 Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	(1) 2 3 4 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	(1) 2 3 4 5
3. I was encouraged to express my vies about what would be helpful for me and my family.	(1) 2 3 4 5
4. Meetings were planned at times and places that were good for my family.	(1) 2 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	(1) 2 3 4 5
6. I was satisfied with the role I played in developing the plan of services for my family.	(1) 2 3 4 5
7. The services I received at Kinark helped.	(1) 2 3 4 5
8. I received enough service.	(1) 2 3 4 5
9. I would recommend Kinark to others or use it again for my family	(1) 2 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

(1) Very Good | 2 Good | 3 Neither Good Nor Poor | 4 Poor | 5 Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

- physical violence has ended
- verbal abuse + language improved

If I could change one thing about Kinark, it would be:

Any other comments or suggestions?

Thank you for your help!

KINARK CHILD AND FAMILY SERVICES

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: KATIE, B (MR. B)

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: ✓

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: ___

I DO NOT WISH TO COMPLETE THIS FORM: ___

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1	2	3	4	5
Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	1 (2) 3 (4) 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	(1) 2 3 4 5
3. I was encouraged to express my vies about what would be helpful for me and my family.	1 (2) 3 4 5
4. Meetings were planned at times and places that were good for my family.	(1) 2 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	1 (2) 3 4 5
6. I was satisfied with the role I played in developing the plan of services for my family.	1 (2) 3 4 5
7. The services I received at Kinark helped.	1 (2) 3 4 5
8. I received enough service.	1 2 (3) 4 5
9. I would recommend Kinark to others or use it again for my family	1 (2) 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

1	2	3	4	5
(Very Good)	Good	Neither Good Nor Poor	Poor	Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

- open discussions.

If I could change one thing about Kinark, it would be:

- more sessions required.

Any other comments or suggestions?

Thank you for your help!

KINARK CHILD AND FAMILY SERVICES

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: Katie B (John)

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: ✓

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: _____

I DO NOT WISH TO COMPLETE THIS FORM: _____

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1	2	3	4	5
Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	1 (2) 3 4 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	(1) 2 3 4 5
3. I was encouraged to express my vies about what would be helpful for me and my family.	(1) 2 3 4 5
4. Meetings were planned at times and places that were good for my family.	(1) 2 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	(1) 2 3 4 5
6. I was satisfied with the role I played in developing the plan of services for my family.	(1) 2 3 4 5
7. The services I received at Kinark helped.	1 (2) 3 4 5
8. I received enough service.	1 2 (3) 4 5
9. I would recommend Kinark to others or use it again for my family	(1) 2 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

(1)	2	3	4	5
Very Good	Good	Neither Good Nor Poor	Poor	Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

Could say what was on my mind
Gave suggestions of what would help

If I could change one thing about Kinark, it would be:

Any other comments or suggestions?

Thank you for your help!

KINARK CHILD AND FAMILY SERVICES

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: ____ KATIE B. (CHRS. B)

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: ✓

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: _____

I DO NOT WISH TO COMPLETE THIS FORM: _____

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1	2	3	4	5
Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	1 (2) 3 4 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	(1) 2 3 4 5
3. I was encouraged to express my vies about what would be helpful for me and my family.	(1) 2 3 4 5
4. Meetings were planned at times and places that were good for my family.	1 (2) 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	(1) 2 3 4 5
6. I was satisfied with the role I played in developing the plan of services for my family.	(1) 2 3 4 5
7. The services I received at Kinark helped.	1 (2) 3 4 5
8. I received enough service.	1 2 (3) 4 5
9. I would recommend Kinark to others or use it again for my family	(1) 2 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

(1)	2	3	4	5
Very Good	Good	Neither Good Nor Poor	Poor	Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

- teamwork with husband - we learned how to work together

If I could change one thing about Kinark, it would be:

lengthier involvement - more sessions needed

Any other comments or suggestions?

Thank you for your help!

KINARK CHILD AND FAMILY SERVICES KATIE B -

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: Katie B

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: ✓

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: _____

I DO NOT WISH TO COMPLETE THIS FORM: _____

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1	2	3	4	5
Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	(1) 2 3 4 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	(1) 2 3 4 5
3. I was encouraged to express my vies about what would be helpful for me and my family.	1 (2) 3 4 5
4. Meetings were planned at times and places that were good for my family.	(1) 2 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	(1) 2 3 4 5
6. I was satisfied with the role I played in developing the plan of services for my family.	1 (2) 3 4 5
7. The services I received at Kinark helped.	1 (2) 3 4 5
8. I received enough service.	(1) (2) 3 4 5
9. I would recommend Kinark to others or use it again for my family	(1) 2 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

(1)	2	3	4	5
Very Good	Good	Neither Good Nor Poor	Poor	Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

It was the best help
our family has received yet.
I wanted to get involved, and
I could voice my opinion

If I could change one thing about Kinark, it would be:

Any other comments or suggestions?

Thank you for your help!

KINARK CHILD AND FAMILY SERVICES

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: Mark e

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: ✓

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: _____

I DO NOT WISH TO COMPLETE THIS FORM: _____

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1 Strongly Agree 2 Agree 3 Not Sure 4 Disagree 5 Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	(1) 2 3 4 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	1 (2) 3 4 5
3. I was encouraged to express my vies (views) about what would be helpful for me and my family.	1 (2) 3 4 5
4. Meetings were planned at times and places that were good for my family.	(1) 2 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	(1) 2 3 4 5
6. I was satisfied with the role I played in developing the plan of services for my family.	(1) 2 3 4 5
7. The services I received at Kinark helped.	1 (2) 3 4 5
8. I received enough service.	1 2 (3) 4 5
9. I would recommend Kinark to others or use it again for my family	(1) 2 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

(1) Very Good 2 Good 3 Neither Good Nor Poor 4 Poor 5 Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

The tips we received from our worker on how to deal with certain situations along with a more detailed and more neutral point of view as to what behavior and situation was caused by the A.D.D. and what wasn't.

If I could change one thing about Kinark, it would be:

N/A

Any other comments or suggestions?

N/A

Thank you for your help!

KINARK CHILD AND FAMILY SERVICES

CLIENT SATISFACTION QUESTIONNAIRE Name of Child: Mark C

To help Kinark Child and Family Services continue to provide quality services in the community, we greatly appreciate your opinion. Please start by telling us if we can share your comments with your workers. (Check off your choice below).

YES, YOU CAN SHOW THIS FORM TO MY WORKERS: ✓

PLEASE, DO NOT SHOW THIS FORM TO MY WORKERS: _____

I DO NOT WISH TO COMPLETE THIS FORM: _____

Please circle the number to the right of each comment that most closely represents your view using the following scale:

1	2	3	4	5
Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree

COMMENT	YOUR VIEW
1. I was well informed by staff about what I could expect from Kinark at the beginning of our involvement.	(1) 2 3 4 5
2. I was encouraged to provide information about my child and family to help staff understand my concerns	1 (2) 3 4 5
3. I was encouraged to express my vies (views) about what would be helpful for me and my family.	1 (2) 3 4 5
4. Meetings were planned at times and places that were good for my family.	(1) 2 3 4 5
5. I was encouraged to speak up during meetings and conferences if there was something I wanted to say.	(1) 2 3 4.5
6. I was satisfied with the role I played in developing the plan of services for my family.	(1) 2 3 4 5
7. The services I received at Kinark helped.	1 (2) 3 4 5
8. I received enough service.	1 2 (3) 4 5
9. I would recommend Kinark to others or use it again for my family	(1) 2 3 4 5

Please circle one of the following:

10. Overall, how would you rate the quality of the services you received from Kinark?

(1)	2	3	4	5
Very Good	Good	Neither Good Nor Poor	Poor	Very Poor

PLEASE WRITE YOUR COMMENTS

The thing I liked best about my involvement with Kinark was:

The tips we received from our worker on how to deal with certain situations along with a more detailed and more neutral point of view as to what behavior and situation was caused by the A.D.D. and what wasn't.

If I could change one thing about Kinark, it would be:

N/A

Any other comments or suggestions?

N/A

Thank you for your help!