INTERVENING WITH FAMILIES AT THE ADOLESCENT STAGE OF THE FAMILY LIFE CYCLE: IMPLICATIONS FOR FAMILY PRACTICE

BY

ANNE-MARIE SHANKOWSKY

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

MASTERS OF SOCIAL WORK

School of Social Work
University of Manitoba
Winnipeg, Manitoba

ISBN 0-315-77753-2

Canada

INTERVENING WITH FAMILIES AT THE ADOLESCENT STAGE OF THE FAMILY LIFE-CYCLE: IMPLICATIONS FOR FAMILY PRACTICE

BY

ANNE-MARIE SHANKOWSKY

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

MASTER OF SOCIAL WORK

FOR ROBERT NOEL DEGAGNE

AND TO

ELIZABETH HILL

"REACH FOR THE STARS --- FOR EVERY PERSON IS A STUDENT"
(Ada Morrison, 1991)

ACKNOWLEDGEMENTS

THANKS TO:

.....Betsy, whose belief in family systems work supported me during my practicum placement;

.....Jan and Jim, who provided relief and fuel;

.....Diane and Dave, who kept me going - in more ways than one;

.....Thelma, for being there with her marvelous cures;

.....Yvonne, whose thoughtful and unexpected message brightened my day;

.....Bev, who taught me more about valuing experience. I am grateful;

....France and Marg, who bring new beginnings and other possibilities;

.....Rose, Tracy, and other members of the study group, for their sharing and encouragement;

.....Barry, Harvy, and Zain, my practicum committee, for their guidance and patience; and Elizabeth Hill, instructor and practicum committee member - her memory has left a mark;

.....Jenny and Evan, who provide a constant source of energy, excitement and uncertainty. Their struggles inspired me on;

.....Dan, who believed in me;

.....Finally, to the families - parents and children, who bring their pain and hurt, and take a risk by asking for help, trusting the unknown.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

CHAPTER ONE
Introduction 1

CHAPTER TWO
Literature Review 4
Introduction 4
Integration of Structural/Strategic Themes 4
Structural Theme 5
Structural Tasks 7
Interventive Strategy 8
Strategic Theme 9
Basic Strategic Concepts 11
Strategic Techniques 11
Intervention: Use of Paradox 12
Intervention: Use of Circular Interview 14
Communication Theme 16
Four Aspects of Family Life 18
Five Patterns of Communication 18
Therapeutic Elements 19
Developmental Theme 20
The Family Life Cycle - An Overview 20
Adolescent and Launching Stages 21
Tasks of Parents at the Adolescent and Launching Stages 22
Family Developmental Reactions to Crisis 23
Adolescent Tasks and Issues 24
Adolescent Developmental Reactions to Crisis 29
Crisis Evaluation of Adolescent Development 34
Historical Theme 36
Ecological Theme 37
Summary 38

CHAPTER THREE
Practicum Site and Procedures 39
The Committee 39

The Setting 39
Case Description 40
Description of Evaluation of Intervention 41
The Family Assessment Measure 41
Supervision Procedures 43
Evaluation of Therapist by Clinical Supervisor 43
The Family Therapist Rating Scale 43
Individual Supervision and Group Supervision 44
Therapist Log 45
Focus and Learning Objectives 46

CHAPTER FOUR
Assessment and Intervention of Practicum Families 47
Three Case Studies 48
The Boyd Family: Assessment 48
Previous and Presenting History 48
Genogram 50
Family's Description of the Problem 51
Attempted Solution(s) 51
Communication and Interaction Styles 52
Conflict 52
Affect 52
Family Structure 52
Negotiation 53
Hypothesis 53
Pertinent Family-of-Origin Information 53
Other Information 53
Therapeutic Goals 53
Proposed Treatment 54
Interventions 54
Intervention: Task Assignment - Homework 56
Evaluation of Task Assignment as an Intervention 56
Further Intervention, Assessment and Evaluation 57
Pre/Post Therapy Profile 59

The Taylor Family: Assessment 63
Previous and Presenting History 63
Genogram 64
Family's Description of the Problem 65

Attempted Solutions 65
Communication and Interaction Styles 65
Conflict 66
Affect 66
Family Structure 66
Pertinent Family-of-Origin Information 66
External Sources of Stress and Support 67
Recent Crisis or Extended Family Crisis 67
Hypotheses 67
Therapeutic Goals 68
Proposed Treatment 68
Evaluation of Use of Circular Questioning 69
Further Intervention, Assessment and Evaluation 69
Pre/Post Therapy Profile 70

The Robb Family: Assessment 75
Previous and Presenting History 75
Genogram 76
Family's Description of the Problem 77
Attempted Solutions 77
Communication and Interaction Styles 77
Family Structure 78
Hypothesis 78
Pertinent Family-of-Origin Information 78
Therapeutic Goals 79
Proposed Treatment 79
Evaluation of Use of Paradoxical Intervention 79
Further Intervention, Assessment and Evaluation 80
Pre/Post Profile 83

CHAPTER FIVE
Evaluation of Therapist by Clinical Supervisor 86
Individual Supervision 86
Group Supervision 86
Family Therapist Rating Scale(FTRS) 87
Description of Implementation of the FTRS 87
Family Therapist Rating Scale Profile 88

Pre/Post Family Rating Scale Profile 89
Evaluation of use of the FTRS 90
Therapist Log 90
Summary 91

CHAPTER SIX
Summary, Conclusion and Recommendations 93

BIBLIOGRAPHY 100

Appendix A: Family Assessment Form 105
Appendix B: Robb Family Letter 112
Appendix C: Letter of Permission 114

FOOTNOTES 115

CHAPTER ONE

Introduction

Families with adolescents pose challenging and exciting dilemmas. In order to respond to these dilemmas, it is helpful for the practitioner to adopt an approach in which many options are available. One such approach is family therapy. Family therapy is considered a powerful treatment intervention when working with adolescents (Fishman, 1988). This method includes significant people in the adolescent's life and it encompasses the social environment in which the adolescent has grown and from which s/he will soon emerge. Rather than treating a problem, the focus for the family practitioner will be on the social context that is associated with the problem. At one level, a systemic perspective provides a framework in which individuals are viewed within the context of their families. At a more global level, a systemic perspective addresses the transactional relationships between the individual, the family and larger socio-cultural context (Hartman and Laird, 1983; Minuchin, 1974). A systemic perspective emphasizes the relational aspect among these levels. As well, a systemic perspective considers how these levels i. e., the individual, the family, and the socio-cultural context are organized together as a single, functioning whole system. Therefore, as the family represents part of the larger environment, it at the same time forms an environment for the individual (Hartman and Laird). This practicum seeks to address the family as a primary target for change given that the family provides a social context for the adolescent, and given that the family is part of the larger socio-

cultural context.

This clinical practicum primarily focused on the application of structural and strategic models of family therapy with families in which an adolescent member was identified as requiring treatment, by the family or a community referral source (e.g., school, social services, other therapists).

The focus of this practicum encouraged the acquisition of clinical skills at a number of levels. First, specialized skills were developed in conducting family therapy with families at the adolescent stage of the family life cycle. Second, the practicum provided an opportunity for this practitioner to concentrate on development of therapist skills.

Since this clinical practicum took place in the practitioner's place of employment, experiences and observations would be noted.

Chapter Two considers and describes themes which outline the literature of the major models of family treatment. An explanation of the integration of structural and strategic themes is given. Specific tasks, techniques, concepts and interventions pertinent to treatment are described. The communication theme advocates use of five steps so that a "win-win" posture can be developed. Four aspects of family life, five patterns of communication and use of specific therapeutic elements are some useful tools and techniques described to understand and intervene with families at the adolescent stage of development. The developmental theme appropriately describes families at the adolescent stage of development as reaching an "intersection point" where there is a quantum leap in anxiety in the family system. This intense time for family members precipitates crisis for the family and the adolescent as all members are struggling to adjust to necessary changes and tasks. Parental tasks, adolescent tasks and issues, and

possible family developmental reactions to crisis, and adolescent developmental reactions to crisis are described. Some guidelines are given in order to evaluate these crisis. This practitioner considered historical and ecological themes briefly. These themes describe changes in family organization, and patterns of family environment relationship responses.

An explanation of the practicum site and practicum procedures are detailed in Chapter Three. Specifically, committee members, practicum setting, case description, description of the evaluation of therapy, supervision procedures, and learning objectives are described.

Assessment and intervention with practicum families is detailed in Chapter Four. Utilization of the Family Assessment Form (Mohammed, 1983) provided a format for assessment of all clinical families. Three case studies are described with intervention, and theoretical underpinnings. The Family Assessment Measure (Skinner, Steinhauer, Santa Barbara, 1983) was used to show pre and post outcome measures of family functioning and change for each family.

Chapter five discusses evaluation of the therapist by the clinical supervisor. Use of the Family Therapist Rating Scale (Piercy, 1987), and areas of skill development of therapist behaviours are discussed. Pre and post changes in structuring and relational behaviours are visually demonstrated by use of the FTRS profile.

Chapter Six summarizes what was learned. Several recommendations conclude this paper.

CHAPTER TWO

Literature Review

Introduction

Families struggle with transition and change at every stage of the life cycle but especially at the adolescent stage. These transitions and changes which families at the adolescent stage of the life cycle struggle with are explained by various themes. When families become "stuck" at this stage and a member(s) develops symptomatic behaviour, these problems can be described as a difficulty in the transition or change with one or more of the following themes. These themes will assist the family practitioner to formulate hypothesis and interventions in order to assist the family to cope with the necessary transitions and changes at this stage. When the family at the adolescent stage of the life cycle is successful in completing necessary tasks, members are able to continue their developmental journey.

Integration of Structural/Strategic Themes

Integration of structural/strategic approaches considers the similarities between these two family therapy approaches at the theoretical level. Compatibility of these two approaches on an operational level leads the therapist to apply either a structural or strategic approach, or to use both. Stanton (1981) provides three general rules and three specific situations to apply to decision making about using one approach or the other. The first rule being proposed is to initially deal with a family through a structural

approach. The second general rule is to switch to a predominantly strategic approach when "structural" techniques either are not succeeding or are unlikely to succeed. Following success with strategic methods, and given that a case is to continue in therapy, it may be advisable to revert once again to a structural approach. A switch may be considered in three situations: when no change is occurring, switch from a structural to a strategic approach; determining strategy from prior knowledge; and confusion and loss of "understanding" by the therapist.

Structural Theme

The idealized image of the normal family is that it is nonstressful and has an absence of problems. To help assess a family, Minuchin (1974) outlines the following conceptual schema of family functioning. This schema is based on the family as a system, operating within specific social contexts, and has three components. First, the structure of the family is that of an open sociocultural system in transformation. Second, the family undergoes development moving through a number of stages that require restructuring. Third, the family adapts to changed circumstances so as to maintain continuity and enhance the psychosocial growth of each member. For example, Minuchin states that during the emergence of the child into adolescence, the child's participation and status increase in their extrafamilial world. Dislocation of the relationship between the parent and child occur. The adolescent moves away from the sibling subsystem and is given increased autonomy and responsibility which is age appropriate. Parental transactions change from parent-child to parent-young adult, and result in successful adaptation. Furthermore, Minuchin states that the process of these transactional patterns include a power hierarchy, in which parents and children have different levels of

authority; in which there are complementarity of functions, with the husband and wife accepting interdependency and operating as a team; and in which mutual expectations of particular family members involve implicit and explicit negotiation.

Part of the structure of the family is determined by the boundaries. The boundaries are the rules defining the transactions of the family members. Clear boundaries allow functional transactions between family members. Two extremes of these transactional styles are referred to as enmeshment and disengagement. This preference for a type of interaction as noted by Minuchin, is not meant to refer to a qualitative difference between functional and dysfunctional transactions.

Another part of the structure of the family is determined by subsystems. According to Minuchin, subsystems include: spousal-formed when 2 adults of the opposite sex join with the express purpose of forming a family; parental-a new level of family formation reached with the birth of the first child; and sibling-first social laboratory in which children can experiment with peer relationships (Minuchin, 1974, p 59). Boundaries functioning between subsystems can be at the extremes of rigidity or diffuseness, with most families falling within the wide normal range.

The family's capacity to adapt to demands from within and without requires constant transformation of the position of family members in relation to one another, so they can grow while the family system maintains continuity. Given these constant changes and transitions to new experiences requiring adaption, three sources of stress emerge. They are: stressful contact of one member or of the whole family with extrafamilial forces, transitional points in the family's evolution and idiosyncratic problems.

Structural Tasks

Before proceeding, the therapist must join with the family to create a therapeutic context, and the therapist must understand the family structure. The ongoing task of joining with the family is accomplished by the therapist by accepting the families organization and style, and blending with them. Minuchin describes these underpinnings of therapy as involving the processes of joining and accommodation. Minuchin (1974) describes techniques of joining and accommodation as involving: (1) maintenance, in which the therapist supports the existing family structure; (2)tracking, in which the therapist attends to the family's communication and behaviour patterns; (3) mimesis, in which the therapist joins the family by adopting the family's pace, style and affective range

Evolving from experiences and observations of the therapist joining with the family is the formulation of a diagnosis or working hypothesis. This diagnosis according to Minuchin should consider six areas. They are: 1.The family structure in terms of its major subsystems; 2. The system's flexibility and its capacity for elaboration and restructuring, as revealed by the reshuffling of the alliances, coalitions, and subsystems in response to changing circumstance; 3. The system's resonance, its sensitivity to individual member's actions; 4. The system's context, its life-support systems and the sources of stress in its extrafamilial environment; 5. The family's developmental stage and its performance of tasks appropriate to that stage; 6. The ways in which the identified patient's symptoms are used to maintain the current transactional patterns

As joining and the formulation of a hypothesis are established, the therapist establishes a contract with the family for the continuation of the process of therapy. Once this contract is established the therapist can proceed.

Interventive Strategy

The assignment of a task is designed to make changes in the organizational structure of the family system. The purpose of a structural technique according to Sherman (1986) is to reorganize the family system by getting members to move from one place to another, from one role to another, and to establish and reinforce appropriate boundaries between places in the system, thus causing the system to reorganize itself.

Restructuring the family requires operations which confront and challenge the family to force a change. Structural moves are dramatic interventions that create movement toward therapeutic goal(s). There are at least seven categories of restructuring operations as outlined by Minuchin (1974). They are: 1. actualizing family transactional patterns; 2. marking boundaries; 3. escalating stress; 4. assigning tasks; 5. utilizing symptoms; 6. manipulating mood; and, 7. supporting, educating, or guiding. Every therapist prefers some techniques over others and uses them in different ways according to their own personality and resources. The use of any restructuring operations such as escalating stress or the assignment of a task is for the purpose of intervention. It is important to identify and be aware of which structural move is being used for what purpose when intervening. For example, structural moves can be used for many purposes: 1. Create movement; 2. Change perspectives; 3. Shift distribution of power; 4. Disrupt coalitions; 5. Form new alliances; 6. Clarify boundaries between and among subsystems; 7. Discover new aspects of selves; 8. Normalize the experience of being in a particular place; 9. Reframe the meaning of being in a particular place; 10. Change the family system while working with one individual; according to Sherman (1986).

Strategic Theme

Haley (1980) and Madanes (1981) have focused exclusively on families with adolescents. Haley frames all behaviours as protective and he states that it is this benevolence that poses problems. He identifies youthful madness as taking place at the family life-stage where re-organization is taking place, and that states that the youth's behaviour is adaptive to that social context. This madness takes place in two extreme forms: 1). the adolescent who makes trouble; and 2). the adolescent who is apathetic and helpless, and will not do anything to support themselves. Other characteristics of such young people, as described by Haley are: they are failures; they do not support themselves; they do not train successfully for a means to support themselves; they do not form intimate relationships with other young people and so do not develop a normal social base outside of the family. According to Haley, these incapacitating behaviours are solutions and stabilize the family so that the adolescent continues to need the parents. The adolescent's failure has several functions. These functions are: 1). to let the parents continue to communicate through and about the young person, with the family organization remaining the same; and, 2). a metaphoric message, often a parody or theme which is important to the group, and it is this group issue which is conflictual.

According to Haley, the social situation rather than the act of a person often determines whether they will go to jail or the hospital. Usually, people who are considered not being able to help what they do, go to hospital. People who are considered responsible, therefore having a free choice are considered criminal. These are often poor people who go to jail. Once the young person is placed in a large

institution, inertia is characteristic of that institution. The longer a young person is in custody or treatment the more the young person settles into this "career",thus socially handicapping the person for life.

Madanes (1981) describes severe problems of adolescence, the trouble the teen causes, and the teen's failure in life as becoming the main theme in parents' lives. Although the young person's disruptive behaviour tyrannizes, threatens, and incapacitates the parents, it also brings them together. The parents may be afraid to take charge, however, fearing they will cause harm or that they will be the recipients of harm.

When describing extreme situations between parents and teen, Madanes explains that two hierarchies are incongruous with each other or that these hierarchies conflict paradoxically.

> Two incongruous hierarchies are simultaneously defined in the family. In one, the youth is incompetent, defective and dependent on the parents for protection, food, shelter and money, and the parents are in a superior position and provide for and take care of him. Yet simultaneously another hierarchy is defined in which the parents are dominated by the youth because of his helplessness or threats or dangerous behaviour. If the parents are to be competent parents, they must demand from the youth the behaviour that is appropriate for his age, but doing so may trigger extreme and dangerous behaviour from the youth. If the youth behaves normally, he loses the power that the threats of extreme behaviour gave him over his parents (Madanes, 1981, p 123).

So it is paradoxical to be in charge while simultaneously dominated by those over whom one has control.

Often the youth's behaviour is metaphorical of the disturbing behaviour of a parent. When there is a similarity between the

youth's behaviour and the parent's, Madanes recommends a simple, straight forward approach. That is, a focus would be on resolving the incongruity in the family hierarchy so that the parents will consistently be in a superior position to the youth.

Basic Strategic Concepts

Papp (1980) describes basic concepts of strategic therapy. These concepts are: 1. The family is a self-regulating system; 2. The symptom is a mechanism for the self-regulation of the system; 3. There will be systematic resistance to change because if the symptom is eliminated, that important part of the system will now be unregulated, constituting a threat to the family. The family wants to change the symptom without changing the system which requires it. This is impossible. Therapy is the process of countering resistance to change

Strategic Techniques

Some primary techniques aimed at changing dysfunctional sequence of behaviours shown by the family are:

1. The utilization of tasks and directives. In fact, this emphasis on directives is the cornerstone of the approach.
2. The problem must be put in solvable form. It should be something that can be objectively agreed upon, e.g. counted, observed or measured, so that one can assess if it has actually been influenced.
3. Considerable emphasis is placed on extra-session change--altering the processes occurring outside of the session.
4. Power struggles with the family are generally avoided, the tendency being to take the path of least resistance and use implicit or indirect ways of turning the family's investment to positive use.

> 5. "Positive interpretation" to the family of its symptom(s), motives, and homeostatic tendencies is readily employed.
> 6. "Paradoxical" interventions are common and may be directed toward the whole family or to certain members (Stanton, 1981, p 431).

Intervention: Use of Paradox

> Paradox is a contradiction that follows correct deduction from consistent premises. The most famous and the most frequent studied and reported is that class known as the "Be Spontaneous Paradox." A command to be spontaneous creates a no-win situation. The person who refuses to act spontaneously remains unspontaneous. Anything that is initiated is only a reaction to the command and hence not spontaneous (Sherman, 1986, p. 189).

Paradox confronts each of us daily in many aspects of our existence. Family therapists have developed various ways in which the paradox can be used or applied. According to Weeks and L'Abate (1982) paradoxical intervention is especially appropriate for families with adolescents. These families exhibit dysfunctional transactions such as: expressive fighting and bickering, unwillingness to cooperate with each other and complete assignments; continuation of same patterns in spite of all types of intervention, dividing and conquering, and disqualifications. Paradoxical intervention would aim to transform these patterns structurally and/or communicationally.

In order to therapeutically prepare for the use of paradoxical interventions, several steps are necessary. These steps as described by Papp (1980) are: 1. Redefining. The problem behaviour is relabeled and presented to the family in a different framework of

meaning which supports the inner logic of the family. 2. Prescribing. The therapist prescribes that the members do more of the same because the family needs the behaviour to continue. 3. Restraining. When the family shows signs of changing, the therapist cautions the family against change.

Paradoxical methods are used both within and outside the therapy session. The use of written communication is one way to apply a paradoxical intervention outside of the therapy session. Letter writing is often a clear and concise way to intervene with all family members. These permanent messages can be a useful way to ensure family members receive verbal communications. As well, written messages allow time for family members to absorb and think about the content of the message without the emotionally loaded exchange which accompanies verbal exchanges.

Michael White (1989), elaborates on the practical use of letter writing in the therapeutic context. A therapy which uses a narrative mode would take a form that:

> 1. privileges the person's lived experience;
>
> 2. encourages a perception of a changing world through the plotting or linking of lived experience through the temporal dimensions;
>
> 3. invokes the subjunctive mood in the triggering of presuppositions, the establishment of implicit meaning, and in the generation of multiple perspective;
>
> 4. encourages polysemy and the use of ordinary, poetic and picturesque language in the description of experience and in the endeavour to construct new stories;
>
> 5. invites a reflexive posture and an appreciation of one's participation in interpretive acts;

6.encourages a sense of authorship and re-authorship of one's lives and relationships in a telling and retelling of one's story;

7. acknowledges that stories are co-produced and endeavours to establish conditions under which the "subject" becomes the privileged author;

8. consistently inserts pronouns "I" and "you" in the description of events (p 49).

Intervention: Use of The Circular Interview

Circularity and hypothesizing are fundamental concepts of family systems orientation to therapy, and should not be viewed as model specific according to Nelson (1986). The essence of circularity is the implication that behaviours and beliefs do not occur in isolation. A circular perspective emphasizes sequences of interactions, that is, patterns of relating and believing, which interconnect family beliefs. During the circular interview, the therapist asks "relationship questions" to provide new contextual information to the family. Circular questions asked by the therapist are varied. Differences among these questions are not trivial. Karl Tomm (1988) offers a framework for distinguishing four major groups of questions.

These groups are:

1. Lineal Questions : are asked to orient the therapist to the client's situation and are based on lineal assumptions about the nature of mental phenomena. The intent behind these questions is predominantly investigative...
2. Circular Questions: are also asked to orient the therapist to the client's situation, but they are based on

> circular assumptions about the nature of mental phenomena. The intent behind these questions is predominantly exploratory...
> 3. Strategic Questions: are asked in order to influence the client or family in a specific manner, and are based on lineal assumptions about the nature of the therapeutic process. The intent behind these questions is predominantly corrective...
> 4. Reflexive Questions: are intended to influence the client or family in an indirect or general manner, and are based on circular assumptions about the nature of the process taking place in the therapeutic system. The intent behind these questions is predominantly facilitative ...(Tomm, 1988, p 6-9).

Use of circular questions is a means to systemically interview changes and differences in family relationships, gather information to generate hypothesis and interventions, and provide an opportunity for the family to view itself systemically. This form of questioning serves as an efficient process for soliciting information from each member of the family regarding their opinions and experience. Although the variety of circular questions are endless, Nelson (1986) classifies four major categories of circular questions: (a) Problem Definition; (b) Sequence of Interaction; (c) Comparison/Classification; and (d) Interventive Circular Questioning. The therapist uses the categories of circular questioning as an efficient process to obtain information from each family member, about their experience and perspective. The relational information obtained by the family and therapist enables the therapist to generate hypotheses and design interventions which interrupt dysfunctional patterns, and which challenge beliefs and myths which support symptoms.

Communication Theme

Remembering that there is no quick or easy negotiating of the adolescent stage, Satir (1988), comments on both parents and adolescents. She states that many parents meet this period with negative fantasies stemming from memories of their own adolescence. As well, horror stories about teen abuses of alcohol, drugs, sex and violence, influence these parents with their own adolescent. Adults with positive images create a context in which growth can take place in a way which preserves the adolescents' dignity, develops their sense of self-worth, and gives them useful guidelines, so that they can become socially mature.

The teenager, on the other hand, has a difficult job as energy moves s/he where there are no marked paths to follow. Satir states that when the adolescent plays with power, autonomy, dependence and independence the adolescent's psychological context (facilitated by adults) needs to allow awkwardness, mood swings, seemingly irrational ideas, occasional bizarre behaviour and new vocabulary. Wise parents are accepting of their teen's restlessness and find graceful ways of living while adolescent temporary storms rage.

Approaching the adolescent with love rather than fear will often be the difference between success and failure, texturing and scarring. Satir describes texturing as coming from using oneself to accumulate wisdom through learning to deal with one's frustrations and conflicts, becoming responsible, and meeting other life realities; and scarring as coming from a result of a broken spirit. Parents who have healed their own wounds will be more able to deal well with their teenager.

Molin (1986) considers suicidal or self-destructive behaviours by adolescents as an act which implies that the family's rules of

communication preclude the use or effectiveness of any less drastic means of communication. Furthermore, he describes that for the adolescent this behaviour is not simply an expression of individual symptomatology, it is in the context of the family, behaviour which is activated by specific family contexts and crisis. Societal forces also add to the denial by the adolescent and the family of suicidal intent of self-destructive behaviours.

When a power struggle exists between parent and teen, a "win-lose" attitude prevails reinforcing control, punishment and threat. Since no change will occur by control or threat, Satir describes five steps to develop a foundation for change so that a "win-win" posture can teach negotiation and creativity. These five steps are:

> 1. You, the parent, need to spell out fears so your teenager can hear them.
>
> 2. You, the adolescent, need to say what is happening with you and be believed; you need to tell your fears and know you will be heard without criticism or ridicule.
>
> 3. You, the parent, need to show willingness to listen and to show that you understand. Understanding does not equal excusing. It simply provides a clear basis from which to go forward.
>
> 4. You, the adolescent, can make it clear that you need your parent to listen, not give advice unless you ask for it.
>
> 5. You, the parent, need to understand that your teenager may not act on the advice you give (Satir, 1988, p 316-317).

Adults who are clear about limits, act in accordance with them and keep agreements based on limits and support will facilitate

trust, respect, understanding and clarity. Teenagers have the right to expect their parents to take the initiative in providing these limits. When adults support the adolescent "discovery process" everyone enjoys maximum outcomes with minimum disruptive risk. At the end of the adolescent stage Satir suggests a ritual celebration take place to validate the new status between parents and child.

Four Aspects of Family Life

Satir (1972), considers the family to be the 'factory' where people are made. She describes the adults in the family, as the 'people-makers'. Aspects of family life which the therapist needs to consider are:

> the feelings and ideas one has about himself, which I call self-worth;
> the ways people work out to make meaning with one another, which I call communication;
> the rules people use for how they should feel and act, which eventually develop into what I call the family system; and
> the way people relate to other people and institutions outside the family, which I call the link to society (Satir, 1972, p 3).

Five Patterns of Communication

Of the four aspects of family life, Satir (1972) considers communication as the greatest single factor affecting a person's health and his relationship to others. These patterns of communication reflect peoples' responses to handling stress, and are especially observable when a person with little self-esteem is

involved.

These five identified patterns of communication are placating, blaming, intellectualizing, distracting and levelling (Satir, 1972). The placator will tend to do just about anything to preclude the others' anger, rejection or judgement. The placating response is a "yes person" trying to please at any cost. This person discounts the self, and has feelings of worthlessness.

The blamer is a fault-finder, a dictator, a boss. The blamer acts superior, and seems to be saying, 'If it weren't for you, everything would be allright.' This person communicates an attitude of blame and accusation. The blamer discounts others, and has feelings of loneliness and unsuccessfulness.

The intellectualizer is very correct, and very reasonable with no semblance of any feelings showing. This person is calm, cool, and collected. This person has feelings of vulnerability, and counts out self and others.

The distractor behaves and speaks with irrelevancies, does not answer questions, and does not address the point of discussion or other interaction. The apparent discord with the environment and self leaves the person feeling alone and generates a further sense of loneliness and/or being misunderstood. This person feels nobody cares.

The leveller behaves and speaks in a way which takes self, other and context into consideration. Words and actions are clear, direct, and congruent.

Therapeutic Elements

The use of sculpture, metaphor, drama, reframing, humor and touch are elements which Satir utilizes in many of her interventions (Satir, 1983). Specific tools and techniques used by Satir are communication stances, simulated family, family reconstruction and

parts party, to name a few.

Developmental Theme

The Family Life Cycle -An Overview

Conceptualizing the family (including three and four generations) as a system,with a view of family behaviour in terms of its life cycle, guides an understanding of how the behaviour of each person in the family directly affects the behaviour of every other member. Problems from this perspective are viewed as interpersonal phenomena in which the family is experiencing significant developmental stages. The individuals within the family system are also in stages of development. McGoldrick (1982) considers change and transition within the family to be incremental until this 'intersection point' of the family stage of development with the adolescent stage of development is reached. When developmental stress intersects with transgenerational stress, there is a quantum leap in anxiety in the system, according to Carter and McGoldrick (1980). Therefore, how well the family will manage its life transitions is largely determined by the degree of anxiety which occurs when developmental and transgenerational stresses intersect.

The concept of time highlights family development in regard to past influences, present behaviours and the family's movement toward the future. Families who get 'stuck' at a particular life stage characteristically lack time perspective , and therapy is viewed as helping them to get back on track developmentally.

Adolescent and Launching Stages

The two stages typically identified to describe families with adolescents are: families whose children are entering the adolescent stage, and families that are launching children. Pittman (1987) describes the inevitability of a crisis of some sort occurring at each developmental stage, but especially at the adolescent phase.

> The family is called upon to adapt to the changing functional capacity or emotional state of the person who is entering a new stage of development. The family's natural response is to slow down, or even punish or prevent, the change. Problems arise when one part of the family tries to prevent the crisis rather than define it and adapt to it. Problems can also occur when someone in the family wants the developmental changes to take place even faster or more dramatically (p 10).

Furthermore,Carter and McGoldrick (1988) define the adolescent stage as ushering in a new era because it marks a new definition of the children within the family, and of the parents' roles with their children. However, it is clear that both the entering and exiting of the adolescent in these stages generates shifts in all relationships across the generations. These shifts parallel and coincide with parents' changes as parents enter midlife and grandparents adjust to retirement and aging, according to Preto (1988).

A three - and sometimes four - generational view of the adolescent phase orients us to issues which exist between nuclear and extended families. A generational view also helps place issues of the presenting problem by considering the family history in the present. McCullough and Rutenberg (1988) state that this generational view lends itself to an appreciation of how family patterns, interactions and connections has influenced and shaped

individual behaviour.

Preto (1988) describes adolescent demands as catalysts which serve to reactivate emotional issues and set triangles in motion between the generations. Therefore, unresolved struggles between adolescent and parent may bring to the surface conflicts between parents and grandparents or between parents. These conflicts and tensions often repeat earlier patterns of relating in the parents' family of origin.

Tasks of Parents at the Adolescent and Launching Stages

A number of tasks and changes must take place for the family and individual members to proceed developmentally according L'Abate (1986). The parents, after a certain degree of confusion and disruption, begin the emotional process of changing rules and limits and reorganizing themselves to allow adolescents more autonomy and independence states Preto (1988). Generally, parents struggle with three main tasks at this time. Parental adjustments are made to changes between the parent-child relationship to allow the adolescent increased autonomy within the family system and also outside it. As well, parents are also responding and shifting their relationships with other family members. Parents may also face major midlife issues when career and/or marriage are reconsidered. Finally, parents are also adjusting to changes with their own parents. As grandparents face retirement and possible move, illness and death, parents may respond to these increased demands.

The 'middle generation' continues changes and transitions of the adolescent phase to the launching phase except that the emotional focus at the launching stage is now on the actual separation of the adolescent from the family and the acceptance of the multitude of exits from and entries into the family system states McCullough et

al. (1988). The 'middle generation' continue previous tasks and transitions which now shift focus to a period of time (considered to be a long stage - college entrance to retirement), involving a renegotiation of relationships into adult-adult behaviours between the grown children and their parents and relationships that include the in-laws and the establishment of roles of the grandparents. This opening, according to McCullough et al. (1988) to review the meaning of the family at every level will be reflected generally by the status of four areas:

> 1. The changing function of marriage.
> 2. The development of adult-to-adult relationships between grown children and their parents.
> 3. The expansion of family relationships to include in-laws and grandchildren.
> 4) The opportunity to resolve relationships with aging parents (p 285).

It is important to consider not only the young adult and their parents, but also multigenerational family patterns. For example, some of the patterns to be considered are the degree of autonomy allowed or ways it can be gained; the expectations and roles of males and females, oldest child and youngest child; and extremes of distance and closeness between the two older generations.

Finally, attempts to resolve issues with the older generation are important. Unless 'unfinished business' is dealt with in some way, both generations will be blocked from the accomplishment of tasks of this particular life stage states McCullough et al. (1988). The degree of resolution between the older and middle generation will undoubtedly effect adolescent development in some way.

Family Developmental Reactions to Crisis

When trouble develops, parents typically identify the problem as

residing in the young adult. Six common patterns are described by Pittman (1987). They are: "Bolt out of the Blue" - an expression of surprise that something might be wrong, as family life had been idealized, conflict was avoided and a high value had been placed on harmony and closeness; conflict is only seen in one person in the family - symptomatic behaviour is one more problem residing in that particular individual; "There's nothing wrong with it', the family and adolescent coalesce to hold onto each other; "We thought we were finished with this' - the young adult responds to unresolved issues in either the total family or the couple; emotional or physical symptoms in the parent, usually the mother, where children have been depended on for emotional support and the adolescent leaving home is perceived as a loss. Symptoms may re-involve distant spouse or there may be an affair, separation or divorce; unusual failure to launch alerts parents to problems in themselves.

Adolescent Tasks and Issues

According to Preto and Travis (1985) adolescents and parents are struggling in many ways, with similar themes of clarifying and evaluating prior decisions made about goals, relationships, autonomy and identity. As the family is performing contradictory tasks of providing safety and security for its members, and at the same time preparing them to individuate, the adolescent is being challenged by developmental tasks on various levels, namely: physical transformation (activating sexual issues); transformations of the self (identity issues); transformations of decision making (autonomy issues); and issues of attachment, separation and loss.

Physical transformation: Sexuality

The adolescent's physical growth and sexual maturation begin the transformation and transition from childhood to adulthood Preto et

al. (1985). Physical and sexual changes dramatically effect how adolescents describe and evaluate themselves and radically alter how they are perceived by others. Coping with this increase in sexual thoughts, feelings and behaviours is a major task for all family members. Parents who are comfortable with their own sexuality are more able to accept and deal with the adolescent's confusion, fear and uncertainty when the adolescent begins to express new sexual interests. When parents openly and appropriately share information about sex and sexuality, set realistic boundaries and limits, and are patient with mistakes made by the adolescent, then a milieu has been provided which allows the expression and experimentation with the development of sexual identity. If parents deny, ignore or reject the adolescent's growing sexuality, the options to develop a positive sexual self-concept are diminished, and the probability of alienation between parents and adolescent increases the risks of premature, excessive or self-endangering sexual activity. Preto et al. (1985) states that the parents' own personal experiences with sexuality influence limits and expectations placed on the adolescent, and also affect the extent to which the adolescent is included in the establishment of rules. With adolescent's emerging sexuality, incestuous impulses between adolescent and the opposite-sex parent are likely to increase. The energy and unacceptability of these urges easily develop into heightened conflict. Preto et al. suggests adolescents act so obnoxiously to make it easier for the parent to let them go, and perhaps parents become difficult to make it easier for adolescent to want to go. For example, a previously special and loving relationship between a father and a daughter evolves into a mutually hostile one, with father being possessive and punitive and daughter being provocative. On the other hand, mothers who have been especially

close to sons experience confusion and conflict when the son demands more privacy and distance. Sons may react to the mother's request for distance and closeness with aggression and rejection and the mother, feeling hurt, may react in a similar manner.

Parents and children of the same sex, on the other hand, tend to become involved in struggles that are more competitive. Assumptions and explanations made to explain this competition are that the same sex pair is competing for attention and love of the opposite sex parent; and another explanation for this competitiveness is that the competition is over conflicting perceptions of appropriate gender roles.

Much of the conflict between parents and adolescents reflects differences in the way each generation interprets the stereotypes and double standards about sexual roles that exist in this society states Preto et al.

Transformation of the Self: Identity

Central to the very experience of adolescence is the search for identity Preto et al defines identity in reference to a person's private view of those traits and characteristics that best describe him or her. This self-structure undergoes its greatest transformation during adolescence. More traditional theories focus on the individuals growth and development, in contrast with the view of the family therapist who consider that while the adolescent is struggling for identity, the other members of the family are also changing. And it is within this family context that the search for identity gets played out.

Preto et al. makes a distinction between how males and females structure their identities. His assumption is that females rely more on relationships and connections, while the emphasis for males is on separation and individuation. He identifies a problematic

notion that developmental theories assume male development as the norm. This is a double bind for women because traits of an 'ideal woman' are not the same as those of an 'ideal adult.' The ideal adult traits characterize the ideal male. This inconsistency in role expectations makes gender consolidation especially difficult for females during adolescence when process is accentuated.

Regardless of theory and gender, adolescent identity formation is a source of excitement, energy and conflict. The adolescent will play out identity struggles between home, community, and school. According to Preto et al. the adolescent confronts and challenges differences and inconsistencies. To establish self-identity the adolescent disagrees with parents about ideas, beliefs and values. This process reflects family therapy view of a gradual renegotiation of the bond between parent and child from asymmetrical authority toward a peer-like mutuality in adulthood. This is in contrast to the traditional view of 'breaking' of the parent-child bond. Attempts to renegotiate can create conflict among generations and lead to struggles over rules, roles and relationships.

Transformation of Decision-Making: Autonomy

To become self-reliant, independent and socially competent, an adolescent must move outside of the family. As alliances with peers and involvement with various adults in the school and community increase, the adolescent becomes less emotionally dependent on his parents and siblings . Preto (1988) states that when adolescents are allowed to participate in decision making but where parents have the ultimate decision, adolescents are more likely to move toward autonomy. Fishman (1985) elaborated by stating that the family is the laboratory where the adolescent learns social skills. The family teaches its members social rules of interaction. These rules which are formed and maintained by the

family tend to be generalized by the adolescent to external situations.

Gender role expectations within the family and larger society also impact greatly on the development of identity, as traditionally males have had more encouragement for educational and occupational advancement.

Attachment, Separation and Loss

Growing up involves transformations of previous attachments, and also involves separation. This process of separation and transition heightens feelings of fear and loss for both the adolescent and the family. To separate in a functional way, the adolescent must be prepared to leave without personal alienation from the family. In this process of separation all individual members of the family must gradually let go emotionally, and then reconnect.

When parents are not working together or are unavailable, difficulties with supporting the task of separation will be unavoidable. Overwhelmed parents may respond to the adolescent by giving up control or attempting to inconsistently control the adolescent.

Families who have experienced early losses and rejections attempt to control their adolescent by keeping them from leaving the family. This control exerted by the parents can take the form of overprotection and thereby reinforce excessive childlike behaviour. The adolescent remains loyal to the family system, meeting parental needs. Preto (1988) says this 'stuckness' is solved by adopting symptomatic behaviour. Haley (1980) explains that regardless of the symptom that is developed, the young person stabilizes the family by continuing to need the parents and therefore to let the parents continue to communicate through and about the young person

with the family organization remaining the same (p 31).

Many conflicts are brought on by what the adolescent needs to do to grow and by parental expectations. To resolve these conflicts, either the adolescent or the parent prematurely separates. When parents give up responsibility and call outside authorities to take control, expulsion may lead to a permanent family rift. The family's capacity to move ahead along its own life cycle may be compromised.

Adolescent Developmental Reactions to Crisis

Depending on which force, 'togetherness' or 'separateness' predominates within a family, Pittman (1987) names symptomatic behaviours developed by the adolescent that can be described as six developmental crises: underground adolescent; sociopathic adolescent; rebellious adolescent; adolescents marked for failure; imperfect adolescents; and rescuing adolescents.

Underground Adolescent

The underground adolescent may eat and sleep at home but is involved very little with other members of the family. Their existence of attendance or non-attendance at school, working, borrowing, selling or stealing from the family or outside the family goes unnoticed. Attempts from the outside to bring problems to the attention of the parents are often intercepted by the adolescent who manages to dodge questions parents have about secrets (such as furtive abortions, hidden cars, apartments, drugs, etc.). The adolescent hides these secrets. Sexual secrets usually begin this underground life. Parents unintentionally help by providing for and protecting the adolescent, allowing the teen to be sexual in private.

The parents of these adolescents are distracted by their own life issues, such as divorce, working, or secret affairs. The parents may have given up the task of parenting, wanting it to end. Parents in this situation have a diminished emotional capacity to respond to the adolescent who desperately needs some rules, guidelines and limits. A crisis may occur when an adult (often not the parent), attempts to control the adolescent. The adolescent may respond by reverting back to an earlier stage of development. This dependence and need for nurturance is often not understood and, the adolescent remains underground states Preto et al. (1985).

Sociopathic Adolescent

Identifying differences in family patterns reveals differences between "sociopathic" and "underground" teens. Sociopathic adolescents come from families where they have been taught to disrespect and break societal rules. Furthermore, this behaviour is not seen as criminal, it is seen as 'smart'. Having learned to emulate parental antisocial actions, adolescents break the law as the adolescent sees the law as the enemy; therefore, lying to authority, taking advantage of others, avoiding obligation and escaping consequences follow these behaviours and attitudes, according to Pittman (1987).

Crisis occurs when the adolescent is caught and the parents respond in some way. If the parents support societal authority, the adolescent may feel betrayed and resent the parents' double standard. The adolescent may force the parents to reevaluate themselves. If this happens, the family may correct themselves and the adolescent will learn that the world's rules are less negotiable and more powerful than the family's rules. Often very rich or very poor parents act in ways that protect the adolescent, by blaming authority figures of the middle class, (namely, teachers or

policemen), with whom they do not identify. They then treat the adolescent as a victim or martyr. Parents respond in ways that keep their teens from facing the world, by applying family punishments for social offenses. By not recognizing the link between their own dishonesty, and the behaviour of their adolescent, their own response is destructive. Teens slip through the crack again as the parents disagree over the child, one parent being punitive, and the other, protective, and this permissiveness undercuts respect for authority, according to Pittman.

Rebellious Adolescent

The "rebellious" adolescent follows the world's rules but makes it known that the need for rules change as they grow and develop. As the adolescent makes known rule-breaking to the parents, open conflict occurs between the adolescent and the parents, not the adolescent and the adult world. Usually this rebellion is intense at puberty, and decreases as parents and adolescent compromise. When negotiation hasn't taken place the battle over rules and punishment persists with the rebellious adolescent learning what will get the balance between freedom and dependency. Actually, the family and therefore the adolescent fears freedom and arranges to have it restricted. So punishment becomes the reward. Freedom asked for is more than can be achieved, and freedom achieved is usually mishandled. This fear of freedom results in the adolescent spending the teen years being "grounded". The rebellion is really then a disguise to hide from a world the parent fears and the adolescent has also learnt to fear.

Adolescents have an abundant capacity to be creative in their rebellion. Clothes, grooming, keeping their rooms to parents' satisfaction , refusal to follow parents' time schedule, resisting opportunities to be together as a family, not visiting relatives, and

chores, are usual adolescent behaviours which reflect normal adolescent disorganization and immaturity. Refusal and challenge by the adolescent are efforts to get the parents to negotiate priorities. To the parents it may seem as if the adolescent wants more freedom than the parents are willing to provide. This mistaken assumption may escalate conflict, as the adolescent is really requesting more structure around anxieties created by increased freedom. When the parents have been unable to resolve anxieties about going out into the world, it will be difficult for them to notice that the adolescent's behaviours are motivated by fear of the very activities the child claims to want desperately, states Pittman (1987). Therefore, the parents will be unable to provide structure around these issues. Pittman suggests that adolescent rebellion should be understood in the context of who is anxious about what, and how that anxiety can firmly and safely be overcome.

Adolescents marked for Failure

Contrasted to the above three crisis of adolescence, the adolescent marked for failure accepts and respects the world but don't like themselves. Even if their parents like them, which is not usual, these adolescents give up and make a show of failing, states Pittman. Often these adolescents have been marked to fail early on by their families, peers and the world. The adolescent expects rejection and sets the stage to be scapegoated. Obvious handicaps (such as blindness, dwarfism, physical handicaps), may receive more support and acceptance than minor deviations from the norm (such as obesity, hyperactivity, learning disability).

For this adolescent, even when relationships both inside and outside the family have been slightly rejecting, the pain expressed by behaviours such as disrupting the class, suicide attempts, depression, far older/younger friends, a sexually exploitive

relationship, and drugs cannot be underestimated.

Imperfect Adolescents

These adolescents succeed with the world but are not accepted within their families. These families have determined a system of values and expectation of members of what and who is good enough. "Imperfect" adolescents are described as kids with stormy tempers in placid families, sloppy kids in neat families, homely kids in beautiful families, and quiet kids in noisy families. These adolescents have characteristics which are not considered defects outside the family but are much criticized and fretted over within the family, according to Pittman. All people have flaws and tendencies to be imperfect. Not accepting or tolerating the less than ideal in themselves or others is a fate worse than the imperfection.

Because adolescents are especially aware and self-conscious, and are normally preoccupied with their real and imagined defects, they are particularly vulnerable to parents, adults and peers calling attention to imperfect tendencies, even inadvertently.

Pittman states crisis for the imperfect adolescent appears when parents become obsessed with this real and/or imagined imperfection, and when the parents may have labelled the adolescent defective.

Rescuing Adolescents

Usually not aware of the "rescuing" role, the adolescent develops symptoms when parents are threatening the continuation of the family in some way. The rescuing role is a self-sacrifice the adolescent makes. Pittman considers alcoholic families to be the most reliable source of training for rescuing adolescents. These

adolescents typically do not acknowledge their role of caring for the home, siblings and sometimes even the parent. They carry a burden of responsibility for others in the family and they may also be required to lie, keep secrets and otherwise carry on a pretense that the family is functioning appropriately. With this full-time job and worry, it is no wonder that the adolescent and one child after the other will develop symptoms that will keep the parents involved with one another, according to Pittman. Although Pittman states that no specific symptom is associated with this syndrome, he describes the classic rescuing adolescent as the runaway. The parents fight perhaps when a sibling is in trouble, and the family is united by the drama created by the adolescents leaving the family. Staging a suicide or becoming violent, becoming depressed, failing in school or withdrawing socially, anorexia, and schizophrenia are all considered possible symptoms of the rescuing adolescent.

Crisis Evaluation of Adolescent Development

Pittman challenges popular thought that all adolescents in crisis are rescuing or rebelling against their parents. He states that although parents may handle adolescent crisis badly, evaluating the family with an adolescent crisis is more complicated. This is so because adolescent norms are so diffuse, and every adolescent is caught between three sets of powerful and conflicting forces, all in flux-the self, the world, and the family.

The six syndromes Pittman poses are to be differentiated from the name of the difficulty, i.e. delinquency, suicidal behaviour, incest, anorexia, schizophrenia, because the syndromes are directly related to treatment. It is important to recognize the limitation that not all adolescent crises fit into six syndromes, and certainly not neatly or for very long.

The following guidelines can be considered when evaluating crisis

of adolescent development. First, are the concerns about the adolescent real or imagined, given differing and contrasting views of the problem that each of the following may have: the world, the adolescent, and parental perception (i.e., one of the parents sees no problem, and the other parents' belief that a problem exists). Regardless, the adolescent's call for help must be answered in some way.

Since society can't be changed with therapy, and since society's views are not negotiable in therapy, the family can be the locus of the problem, according to Pittman. However, often society, specifically the school, can have an instrumental role with either the adolescent, the family or both.

Understanding the overt and covert parameter between parents, adolescents and peers is important in order to determine which secrets can be revealed. Pittman describes a similarity of the iceberg having a constant ratio of eight parts covert to one part overt. With the adolescent it is difficult to determine how much is covert and how much is overt.

There is a tendency for adolescents to see things as permanent, while parents hope everything is a temporary stage of development. Problems arise with temporary or permanent definitions between adolescent and parents. Therefore, it is important to identify who sees the problem as a stage or as doom.

It is also important to differentiate between unique behaviours and conditions, and those that are habitual. Habitual behaviours and conditions are a cause for therapeutic concern. When parents and kids define habitual problems as unique ones, the therapist isn't likely to be very successful until police, school personnel, or someone steps in and defines a problem the family has been ignoring.

Historical Theme

Previous to industrialization, families did not experience 'adolescence' as a distinct stage of family life, according to Hareven (1982) Fishman (1988) and Carter and McGoldrick (1988). Within the last 100 years the family has undergone major changes. Hareven (1982) describes these changes. Briefly, these changes in the organization of the family have been in the loss of flexibility to take in strangers into the household; changes in family function from a multiplicity of functions to private, domestic and child centered retreats; and changes in the life course from an involuntary to voluntary forces controlling the timing of family events, and a characterization of greater rigidity and uniformity in the timing of the passage from one family role to another.

Consideration of these historical changes place an understanding of the present family in today's societal context. As well, this knowledge challenges idealized notions of the family's past, and helps to dispel present myths and beliefs about the family.

With the emergence of the family as we know it today, children began to be perceived as dependents to be nurtured and protected by the family. Contemporary society began to acknowledge and support the adolescent phase of development by providing educational, economic, institutional and familial resources for teens according to Mishne (1986). Furthermore, Mishne states that societal changes are affecting familial style and roles, parental employment patterns, and adolescent peer behavioural norms; and the adolescent perspective has expanded, including broadened social realities, financial dependency, increased academic preparation, and also increased recognition of length of time involved in personality consolidation.

Ecological Theme

This theme focuses on people's strengths, adaptive capacities, and transactions between the person and the environment. Germaine and Gitterman (1980) identify the adolescent stage as a particularly strained life transition as stress is generated. This stress is generated as discrepancies emerge, between the tasks of parents and adolescent, in dealing with conflicting needs and capacities. In addition, the family and adolescent are coping with life transitions, interpersonal processes, and are also dealing with environmental pressures. Therefore, at best, the adaptive demands of all members are stretched.

Garbarino (1982), Hartman and Laird's (1983), emphasis on treatment of systems rather than symptoms, involves a holistic view to understand what the family needs in relationship to environment resources that are available. Generally, this view describes three family environment relationship responses. They are: the deprived family (the more well-known and misused term-multi-problem family); the overburdened family during particular times of the life cycle; and the socially isolated family.

The family's capacity to transact with the socio-cultural context, and its ability to tolerate stress, determines how open or closed its boundaries will be. Patterns of social impoverishment affect children and families. These patterns are described as lack of human and financial resources available to single parent households; the balance or unbalance of power between parents and children; and whether a child is raised in a positive emotional climate producing social momentum or a negative emotional climate producing social deadweight according to Garbarino.

Summary

Transition and change are overriding themes in describing families with adolescents. At no other time does the family have to deal with such complexity and uncertainty. While the family is adjusting to the new demands of the adolescent, it is also responding in some way to the grandparents. While the family responds to these upward and downward pressures, it is also simultaneously being affected and influenced by the larger socio-cultural context. Central themes were presented to understand the complexity of these family transitions and competing forces. These themes outline approaches and techniques of the major models of family therapy. Historical and ecological themes were described to broaden an understanding of the 'present day' family with adolescents in a socio-cultural context.

CHAPTER THREE

Practicum Site and Procedures

The Committee

The advisory committee was composed of Dr. Barry Trute, Dr. Zain Mohammed, and Dr. Harvy Frankel. Dr. Mohammed provided ongoing clinical supervision at the practicum site. Dr. Trute, academic advisor, provided additional clinical supervision.

The Setting

The practicum work was completed at the Lake of the Woods Child Development Centre (LWCDC), a children's mental health treatment centre, located in Kenora, Ontario. This centre provides a multitude of children's mental health and child development services. These services are provided by a speech-language pathologist, an occupational therapist, a physiotherapist, a psychologist, and a counselling staff of approximately six people. Previous to this practicum placement my role as a full-time employee at the LWCDC was 'counselor'.

Dr. Zain Mohammed, a marriage and family therapist, was available for consultation, training and supervision one day per week.

Programs under the umbrella of the Child Development Centre include: the Life Skills Learning Centre, which provides academic and life skills to students (age twelve to eighteen, approximately), unable to function in the regular school system; the Northern Heritage School provides placement for developmentally disadvantaged children (age five to ten, approximately), identified by the educational system's Identification, Placement and Review

Committee; The Adolescent Sex Offender Program - a program for adolescents who have been convicted in Young Offenders court and have been ordered into treatment; and, Integrated Services for Northern Children (ISNC), - a consultation and assessment team available to professionals who work with high risk families and their children in remote and rural areas of Northwestern Ontario. This travelling team consists of a psychiatrist, psychologist, psychometrist, occupational therapist, physiotherapist, a speech-language pathologist, and two teacher diagnosticians.

The catchment area which the Lake of the Woods Child Development Centre services includes: a geographic area west of Kenora to the Manitoba border, east of Kenora to the boundary of Vermillon Bay, north to the community of Minaki, and south to the border of Nestor Falls.

Case Description

Thirteen families were involved in this practicum over a six month period. Direct and indirect contact included a single consultation to a total of 8 sessions. Three families continued in therapy after the practicum was completed. Eleven of these families were at the adolescent stage of the family life cycle; two were at the launching stage.

Entrance point for referrals was via two intake workers. Intake workers gathered information from the referrral source. This would sometimes include an intake interview. Six referrals were self-referrals - (four by the parent-mother, and two by the adolescent). Four of the thirteen referrals were already active in the agency and were referred for family therapy (one of these referrals was originally made by the father). Of the three agency referrals: one referral was from Probation Services, and two referrals were from

Child Welfare. Eleven of these thirteen families had received previous involvement from social service providers.

Families were seen by this therapist as soon as the intake workers completed their involvement. Often this meant a considerable waiting period for the family and the therapist. During the six month practicum period, the therapist received three referrals the first month, four the second, three the third, two the fourth, one the fifth, and none in the sixth and final month.

Description of Evaluation of Therapy Intervention

One assessment measure, The Family Assessment Measure III (FAM III), (Skinner, Steinhauer, Santa Barbara, 1983) was used to evaluate pre and post outcome of family functioning and change. Direct observation by the therapist's supervisor and use of the Family Therapist Rating Scale (FTRS), (Piercy, 1987) was a integral part of evaluating intervention.

The Family Assessment Measure III

The FAM III, was developed by Skinner, Steinhauer and Santa-Barbara (1983). It is a self-report instrument that provides quantitative indices of family strengths and weaknesses. FAM is based on a process model of family functioning, attempting to integrate different approaches to family therapy and research. Seven basic factors of family functioning are identified which include: task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms.

The FAM consists of three components:

1. A General Scale composed of fifty-two items,
2. A Dyadic Relationship Scale composed of forty-two items, and
3. A Self-Rating Scale composed of forty-two items.

For the purposes of this practicum, only the General Scale was used as it focuses on the family as a system measuring the family's level of functioning. The scale provides an overall rating of family functioning in relation to the seven factors (subscales) identified in the process model. In addition, a Social Desirability and Denial Subscale make nine subscales in total.

The FAM III was administered at the end of each first family therapy session. This time was chosen as it was believed that family members would be engaged sufficiently in the process and would therefore, have some investment in completing the scale. It took approximately ten to twenty minutes for family members to answer the FAM III. It is designed for all members of the family over the age of twelve years. Raw scores were translated into standard scores for each subscale. These were then plotted on a graph providing a profile for each scale. This scale identifies scores of forty and below as family strengths; scores above fourty and below sixty as average; and scores sixty and above as weakness or family problem(s).

The FAM III provides the therapist with an objective tool for further examination of family functioning. It provides an overview of family strengths and weaknesses as related to the constructs of the process model and identifies areas of potential difficulties that require further inquiry. The quantitative data collected at the beginning stages of therapy can be used as a baseline measure for evaluating pre and post therapy functioning.

The preliminary analyses to date used a heterogeneous sample of 475 families (N=933 adults, n=502 children) that were tested at various health and social service settings in the Toronto area (Skinner, Steinhauer, Santa-Barbara, 1983). Examination of this data has shown that the FAM scales are reliable, and that they

significantly differentiate between problem and nonproblem families. With respect to reliability, coefficient alpha provides a lower bound estimate of the population reliability (ratio of true score to observed score variance). Overall rating estimates for the general scale are: Adults - .93; Children - .94. These scores are quite respectable as are the scores for the general subscales - ranging from .60 - .87, (Skinner, Steinhauer, Santa-Barbara, 1983).

The purpose of use of the evaluation measure was: 1. to obtain a pre and post therapy measure of the level of health/pathology - strength/weakness of the family; and, 2. to evaluate the suitability and practicality of this measure given the setting and clientele.

Supervision Procedures

Evaluation of Therapist by Clinical Supervisor

The Family Therapist Rating Scale (FTRS), was used by the clinical supervisor to rate the therapist's therapeutic skill. Two basic sets of skills - structuring and relationship behaviours - considered necessary for the family therapist were rated. As well, evaluation of the therapist by the clinical supervisor took place in the form of weekly supervision. The therapist participated in supervision on an individual basis and as part of a group. Finally, the therapist kept a log to record experiences and issues during the practicum. This information would be developed into themes relevant to the therapist.

The Family Therapist Rating Scale

The FTRS was developed by Piercy, Laird and Mohammed (1983). It is an instrument developed to enable observers of the therapy session to quantify and compare therapist skills. Its use is advocated for the purpose of opening the therapy session to

observation and live supervision. The rater attends to a limited number of family therapist skills.

Five categories, each with ten items chosen to best discriminate between effective and ineffective behaviours make up the FTRS.

> These five categories of therapeutic behaviours are: structuring behaviours, relationship behaviours, historical behaviours, structural/process behaviours and experiential behaviours (Piercy, Laird, and Mohammed, 1983, p. 170 - 174).

A seven point scale is used to rate each behaviour, thus the therapist can score between zero and sixty. Scores range from zero to six: zero - indicating a specific behaviour "not present"; one - "ineffective"; two - "neutral"; three - "minimally effective"; four - "effective"; five - "very effective"; and six - "maximally effective".

The FTRS is considered simple enough and sound enough to justify its use in supervision and training. Some caution is expressed in its use, however, as much of the reliability and validity data are based on the evaluations of one experienced family therapist.

Individual Supervision and Group Supervision

Evaluation of the therapist by the clinical supervisor took place in the form of supervision. The clinical supervisor and therapist met on a weekly basis, approximately one and a half hours. Audiovideotapes of family sessions provided the basis for case discussion. When possible, live supervision was provided. Issues addressed in supervision were: a) assessment of the family, b) intervention(s) to be used, and c) interaction between the therapist and the family.

The therapist participated in supervision as part of a group. This

group was composed of people interested in receiving training specific to developing skills in family therapy. The clinical supervisor, therapist, other agency therapists (this therapist's colleagues), and a social work student on field placement met on a weekly basis, approximately three and a half hours. Live supervision involved use of the one-way mirror and telephone. The clinical supervisor and group members provided feedback aimed at intervening with the therapist who was involved with the family.

Therapist Log

A component of supervision which combines both the experiential and didactic aspects of supervision is the recording of pertinent process and content in a learning journal. The therapist recorded, at a minimum of once a week, experiences and issues related to practice during the practicum. The information recorded in this log was of a personal nature providing a private resource to the therapist, and reflected the therapist's recognition and acknowledgement of the complexities of considering 'family plus therapist'. According to Simon (1988), "the therapist in the same stage of the life cycle as the family, is not likely to pathologize the situation unnecessarily since they know it from personal experience. On the other hand, there may simply be too many emotional triggers for the therapist to handle (p. 109)."

At times, the therapist choose to share logged entries in the journal during individual and/or group supervision. The purpose of logging practicum experiences and impressions in a journal is threefold: 1. writing about the experience and learning gained from supervision has the effect of improving organization and understanding the material; 2. collecting information on an ongoing manner, will be useful to complete the practicum report; 3. content

of the new learning is retained for future reference and supervision.

Focus and Learning Objectives

The intent of this clinical practicum was to focus on the family system as the primary target for change in which an adolescent member was identified as requiring treatment, by the family or a referral source (e.g., social services, school or other therapists).

The focus of this practicum encouraged the development of clinical skills at various levels. First, focusing specifically on adolescent issues and consecutively, on parental issues at the adolescent stage of the family life cycle, heightened the intensity of clinical practice with a specific clinical population for an extended period of time. Second, the focused nature of the practicum encouraged specialized skills, as well as the development of broader more generalized skills. Third, development of a hypothesis guided intervention in order to produce change in the family system. Fourth, consideration of the therapist's own development in relation to the family provided invaluable information and learning. And fifth, the therapist's observations and experience in the context of the agency would be noted.

CHAPTER FOUR

Assessment and Intervention of Practicum Families

The purpose of assessment is to provide an organizational framework for intervention by the therapist. The process of assessment, intervention, re-assessment of the family system is a continuous one. This process forms a part of the therapeutic encounter. Paramount to the therapeutic encounter is the recognition that families and family functioning are constantly in transition, and that any assessment must reflect this continuous transformation.

For the purposes of this practicum the family unit would be the primary target for change. An integral part of assessment of practicum families was the formation of a hypothesis. This hypothesis was formulated in order to guide intervention(s). These interventions would seek to alleviate the presenting problem and assist family members in developing more satisfactory relationships.

Use of the Family Assessment Measure was for the purpose of obtaining pre and post outcome measures of family functioning and change on practicum families.

A variety of assessment frameworks have been developed by various family therapy theorists. Mohammed (1983) compiled the family assessment form (See Appendix A) which includes concepts from the frameworks of these family therapy theorists. This therapist used some concepts from the family assessment form to organize the experience with the family. During the initial session,

and of course subsequent sessions, the therapist contracts with the family. This contract is one which promotes change in order to alleviate the symptom, and one which seeks to find satisfactory ways in which family members can relate to each other.

. This contract between therapist and family, is achieved through the interactional process of joining. The following case studies reflect the degree to which the therapist and family have 'joined'.

Three Case Studies:

The Boyd Family: Assessment

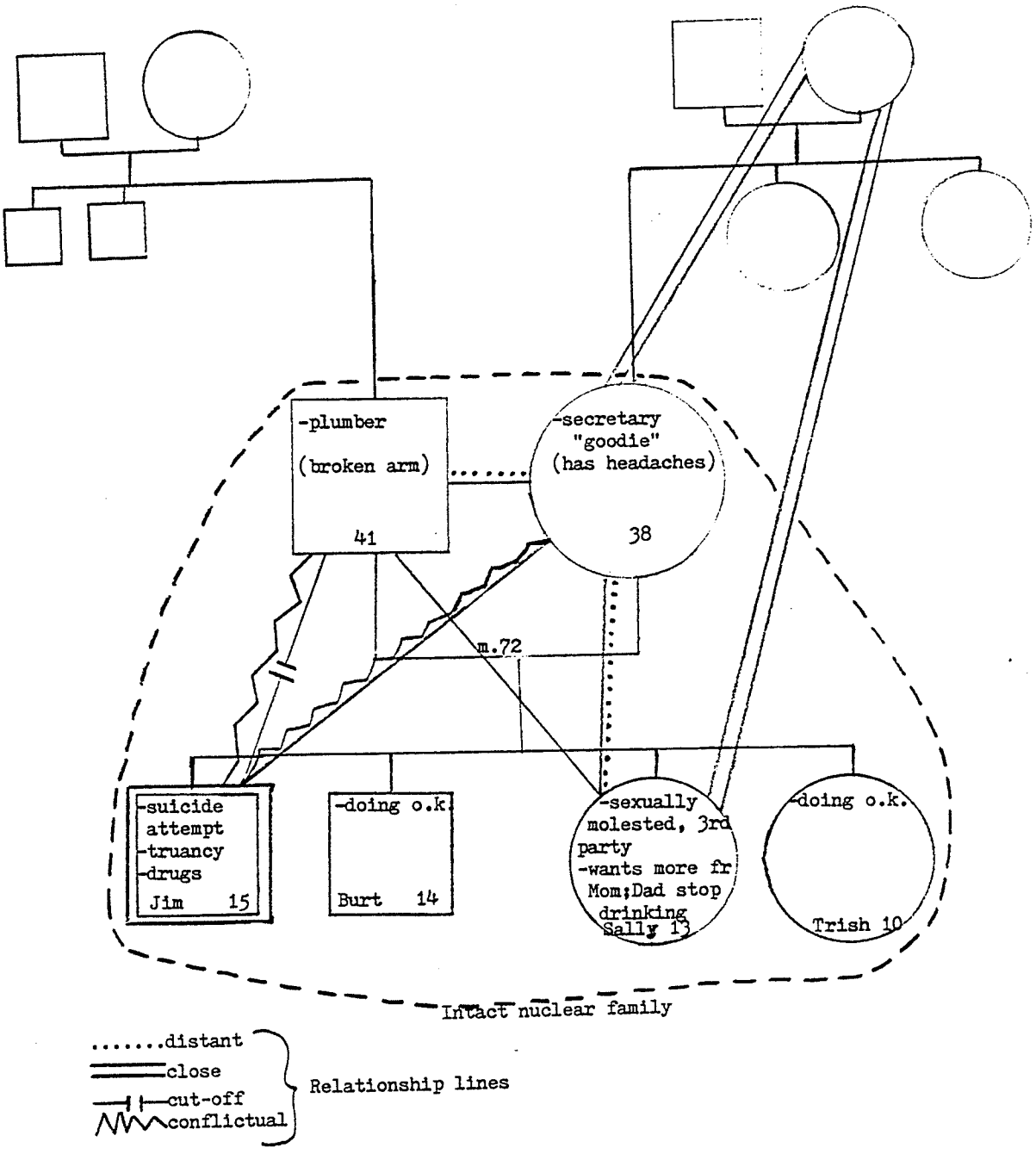
Previous and Presenting History

Jim had initially been referred on two occasions (at age 9 and age 11), by the school in regard to writing difficulties. At that time he was assessed by an occupational therapist who recommended remedial work be done at home and at school. LWCDC involvement ceased as Jim's difficulties were being addressed through the school.

Most recently, Jim (age 13) was referred by his mother whose primary concern was school. Jim was seen individually on at least 7 occasions. As well, he was tested on two occasions by the psychologist. An initial neuropsychological assessment was completed regarding suspicions of a serious learning disability. Test results indicated Jim's lack of achievement in academics could not be blamed on brain-related impairment. Further testing by a psychologist revealed hostility, resentment and possible drug use. Jim's mother then took him to the Manitoba Learning Centre, Winnipeg, Manitoba. Medication was prescribed but the parents discontinued Jim's use of this medication after a two month period.

Jim's individual therapist was leaving the agency, when Jim (now age 15), was referred to this therapist.

Genogram


-plumber
(broken arm)
41
-secretary
"goodie"
(has headaches)
38
m.72
-suicide
attempt
-truancy
-drugs
Jim 15
-doing o.k.
Burt 14
-sexually
molested, 3rd
party
-wants more fr
Mom;Dad stop
drinking
Sally 13
-doing o.k.
Trish 10
Intact nuclear family
.....distant
close
cut-off
conflictual
Relationship lines

Family's Description of the Problem

Mom describes Jim's behaviour as escalating (i.e., skipping out of school, failing grades, increasingly hostile and running away from home). Mom says when she attempts to talk to him he won't listen. She states she wants more co-operation from everyone.

Dad describes no problem with Jim. Grudgingly, Dad states his dislike of Jim's disrespectfulness towards Mom.

Jim states his problem is personal and has nothing to do with the family. He states that the family is boring and has been for a long time. He complains of lack of involvement with Dad. He states he wants a later curfew.

Sally (age 13) states her concerns for Jim are: his suicide attempt four months earlier,and Jim's drug involvement. She states she does not like Dad's drinking. She requests an increased allowance. Sally believes Dad has given up on Jim, and she believes Mom doesn't really know what's going on.

Attempted Solution(s)

The parents, especially Mom, worry about Jim. Mom is often called by the school in regard to their concerns about Jim. She attempts to get Jim to do his school work, and chores around the house. He refuses, and becomes rude and stubborn. Dad steps in when he feels Jim is disrespectful towards Mom, and Jim grudgingly complies. Sally is doing her own thing.

Mom has been searching for solutions outside the family since Jim was nine years of age. She has enlisted the aid of various helpers at LWCDC, the Manitoba Learning Centre and a physician, and she continues to be involved with the school.

The parents express the view that in spending time and energy on Jim, they regret neglecting their other children, especially Sally.

Communication and Interaction Styles

Family members speak about absent members. For example, Dad believes Jim is a failure and says so in front of Mom and Sally. With Jim present Dad describes his concern as Jim failing. Another example is described by Sally, who says (to Mom and Jim but not when Dad is present) Dad's drinking is problematic for her. Mom describes Jim as being like a baby.

Members are simultaneously blaming and protective of each other, and soften their description of the absent member, when that member is present.

Conflict

Open conflict exists on the part of Jim and Sally, directed to the parents. The parents want Jim and Sally to demonstrate concern and responsibility, and Jim and Sally want more independence. The parents disagree about their style of leadership. Dad denies leadership is conflictual. Dad makes quick decisions in regard to the kids without having all the information. Mom, according to Jim, Sally and Dad, is too cautious and takes too long before deciding.

Affect

Although Mom attempts to express feelings of warmth and affection, she is drowned out by the children's anger, hostility and sadness.

Dad stays removed for the most part but brings in humor at times.

Family Structure

Dad is in charge but doesn't acknowledge his dominant role in the family. He defers to Mom, leaving the child-rearing responsibilities up to her. Father is not emotionally involved with the children. Mom attempts, unsuccessfully, to involve the children

and father together by passing messages between them. Sally is the observer in the family system. The myth of family closeness is not challenged by anyone in the family.

Negotiation

Dad distances and mother fills in the blanks for everyone, becoming more responsible. Dad doesn't directly stand up for his views. Differences are expressed but family members are unable to resolve these differences and move forward.

Hypothesis

Jim's behaviours serve the function of providing excitement to the family system, and involve the parents together in such a way that he remains dependent on them. Jim perceives his leaving home may be too threatening to them because his leaving home would push the system to be more flexible to accommodate differences.

Pertinent Family-Of-Origin Information

The family visits Mom's family on a regular basis. Father visits his family, usually on his own.

Other Information

Father has recently broken his arm. He will be at home for approximately six months. This is new for him and the family. Family members express their pleasure in anticipation of father's new involvement.

Parents have 'just' decided to build a new home.

Therapeutic Goals

Three goals of therapy were to: first, engage all family members; second, strengthen the parental system; and third, create flexibility between parental system and sibling system.

Proposed Treatment

The following approaches were proposed to reach the therapeutic goals as stated. First, engagement of all family members involved coaching members who were present to bring in the absent member. Family members were advised of the importance of every members participation and that every member in a family had an important part and role in that family. Asking relational questions when all family members were present had the effect of assisting family members to begin to experience the importance of every member in a new way. As well, bringing in all family members together would reinforce and tie family members together in this process. Second, strengthening the parental system involved making parental styles more overt. Use of the homework assignment provided the parents and adolescents an opportunity to experience and observe each other directly. As well, this experience was sustained over a two week period and then was processed in therapy. Third, creating flexibility between the parental system and the sibling system involved use of the team. The presence of the team and the message which was delivered by the therapist to the family provided additional resources. This message gives information to every family member about their challenge as a family.

Interventions

Dad did not attend the first family therapy session. Mom accounts for Dad's absence as Dad's uncertainty with words and uncomfortableness in talking. Mom, Jim and Sally were coached to bring Dad in to the next session. They succeeded. Dad says he's attending because of his concerns for Sally, who had been sexually molested by a third party.

At the parents' insistence Sally was seen individually. She

minimizes being molested and does not want to attend the pending court appearance. She expresses regret in disclosing the event because she believes it has created more problems for her. At this time she prefers to attend sessions with her family.

After the session which all family members attended, except for Burt and Trish (parents explained Burt and Trish were doing okay, so it wasn't important for them to attend), Jim and Sally expressed the desire to continue. They also expressed protectiveness of each other, especially Dad. In the previous session the therapist had asked each family member to describe what the problem was, what solutions had been tried and could be tried, and what had family members hoped for. The parents described wanting to continue, as they had more questions about their involvement with one another.

A relational question was asked of all family members. That is, "Who is closer to who?" Family members were asked to seat themselves accordingly in the room. The sibling subsystem, Jim and Sally, proceeded so far as to identify themselves as close to each other and emotionally cut-off from the parents. The parents gave their versions as well. The significance of these exchanges was that the parents identified their respective leadership styles and their visions within the family. Dad's vision is for individuality and separateness; Mom's vision is for togetherness and closeness. Sally points out the tensions between the parents in regard to these differences. Dad quickly minimizes Sally's observation by saying that the family is normal. Sally counters Dad by challenging him about his drinking, and the family responded by joking. No further discussion or closure was made on this issue.

In the next session the family was asked what would be happening if there wasn't a problem. Mom's response, "It would be heavenly, I wouldn't have to check over my shoulder." Dad's response, "I would have more time to myself, and things would go more smoothly." Jim

responded, "Things would be boring." Sally responded, "Things would be boring."

Intervention: Task Assignment - Homework

All family members agreed to the following task for a two week period. This task took place at home between the time it was assigned and the next session (approximately two weeks). Starting with Dad, the parents took turns being in charge for three days on and three days off. The parent not in charge would support whatever decision was made by the parent in charge. Jim's and Sally's task was to observe, but not comment on what happened between the parents.

Evaluation of Task Assignment as an Intervention

The task assigned to the Boyd family was aimed both at the presenting problem and the underlying structural problem. The presenting problem is Jim's school failure. The therapist instructed the parents to alternate being in charge. The children were instructed to observe what happened. In this manner, the therapist provided family members with an opportunity to become flexible in their choice of roles and to find alternative transactional patterns amongst one another.

The Boyd family responded to the task assignment in the following ways: First, all members accomplished the task as assigned. A significant change was reported by Mom. Mom reported how 'empowered' she felt, given the opportunity to be in charge. Mom also reported allowing Jim to drive. This was new for her, allowing Jim an opportunity to be independent. As well, she stated her uncertainty as to how close Jim and Sally feel to her.

Another significant change was made by Dad. He reported he had

made a decision about Sally, without Mom knowing, when it was Mom's turn to be in charge. He acknowledged not communicating this with Mom at that time.

Sally directly criticized Mom for taking too long when making a decision. Sally further elaborated by interpreting Mom's speed as 'not trusting'. Jim believed Dad 'trusts' him and Sally "because he makes decisions faster".

Jim was unusually quiet in this session. He described Mom as "two-faced". He aligned himself with his sister. That is he agreed that Dad 'trusts' them because of his ability to make decisions quickly when asked.

Further Intervention, Assessment and Evaluation

Three family sessions followed the task assignment session. The therapist requested group supervision during the second session. During this session the group instructed the therapist to ask the family some questions, such as: "What would happen if Mom was less directly involved in the family?"; "If Dad became more involved, then what would Mom be doing?"; and, "How would the kids be toward Mom if Dad became more involved?"; "What would happen to Mom?"; "Who would complain the most?".

The group and therapist developed the following message which the therapist delivered to the family:

"The family is struggling for closeness and separateness. This struggle involves space and time with each other. This is an issue for every family. Jim and Sally are working together and co-operating between themselves in their efforts to push Mom and Dad together. Jim's and Sally's behaviours are their way of expressing their differences. Many differences exist between the parents. Mom asks a lot of questions and pushes for closeness with Sally and Jim, which they interpret as intrusiveness, so they withhold themselves from her by their behaviours. Dad is more direct about what gets him mad and what doesn't, and Sally and Jim usually respond to him.

We see the parents working hard together. We see the family struggling for closeness and separateness, and wrestling to find a balance between the two. Jim and Sally are working hard to bring the parents together. This process takes time, go slowly in finding this balance. The family's struggle is how differences can be expressed in a way that family members can be more together."
Often these messages are followed by a written letter but the therapist decided against this in this situation.

During these sessions and subsequent ones the therapist observed a number of changes. The parents were more openly communicating their views and differences about leadership between them. Role flexibility was occurring between the parents. Dad was becoming more involved and sharing more of himself, relinquishing some authority. Mom had given up some responsibilities and had experimented with taking on some authority. One of their challenges was to parent in their own way and still support one another.

The sibling subsystem was loosening up by becoming more direct with the parents. Sally was expressing anger more directly to Mom. The alliance between Dad, Sally and Jim was becoming more overt. The challenge for Jim and Sally was to stop working so hard to bring the parents together.

The hostile tone in the sessions had changed to a more hopeful and expectant one. The challenge for the family was to go slowly in finding a balance in their struggle to express differences in a way that they can be together.

The parents initiated termination and came to the last session without Jim and Sally. They spoke of things changing at home. For example, Jim's and Sally's attitude had improved, Jim and Sally were listening more, and were more co-operative inside and outside of the home.

Mother wanted the family sessions to continue, as she felt the "kids were happier", and she described the tone at home as "lighter"

and "more agreeable". Dad felt that they "needed time as a family to do things on their own". He also stated he had decreased his drinking because the kids were being ignored. Father acknowledged that he did not have the solution to Jim's problem. He expressed that family members expected him to be the "problem-solver", and that this expectation was a burden for him.

The therapist asked the parents to struggle with their decision about attending therapy, since this decision was one that they were so clearly divided on. The parents agreed to a follow-up contact in three months time.

Pre/Post Therapy Profile

Although Jim attended the first session during which the FAM was completed, he refused to complete the measure. The therapist did not pursue him. The therapist, via Mom, asked Dad to complete the FAM. He did not, and the therapist felt it would be counter-productive to pursue him . However, father did respond by attending sessions and agreeing to participate in family therapy. Dad, Mom, and Sally completed the post therapy measure at five months. Again, Jim refused.

In total, seven family sessions were held (one was cancelled by the father). Father did not attend the first session, son did not attend the second session and parents attended the last session, deciding not to bring Jim and Sally. In total there were nine direct contacts with this family (including parental session and one individual session held with Sally at the initial stages of therapy).

It is difficult to make statements about the pre/post therapy profile given the absence of father's and son's scores pre therapy, and the absence of the son's scores post therapy.

However, Mom's overall scores decreased, indicating some

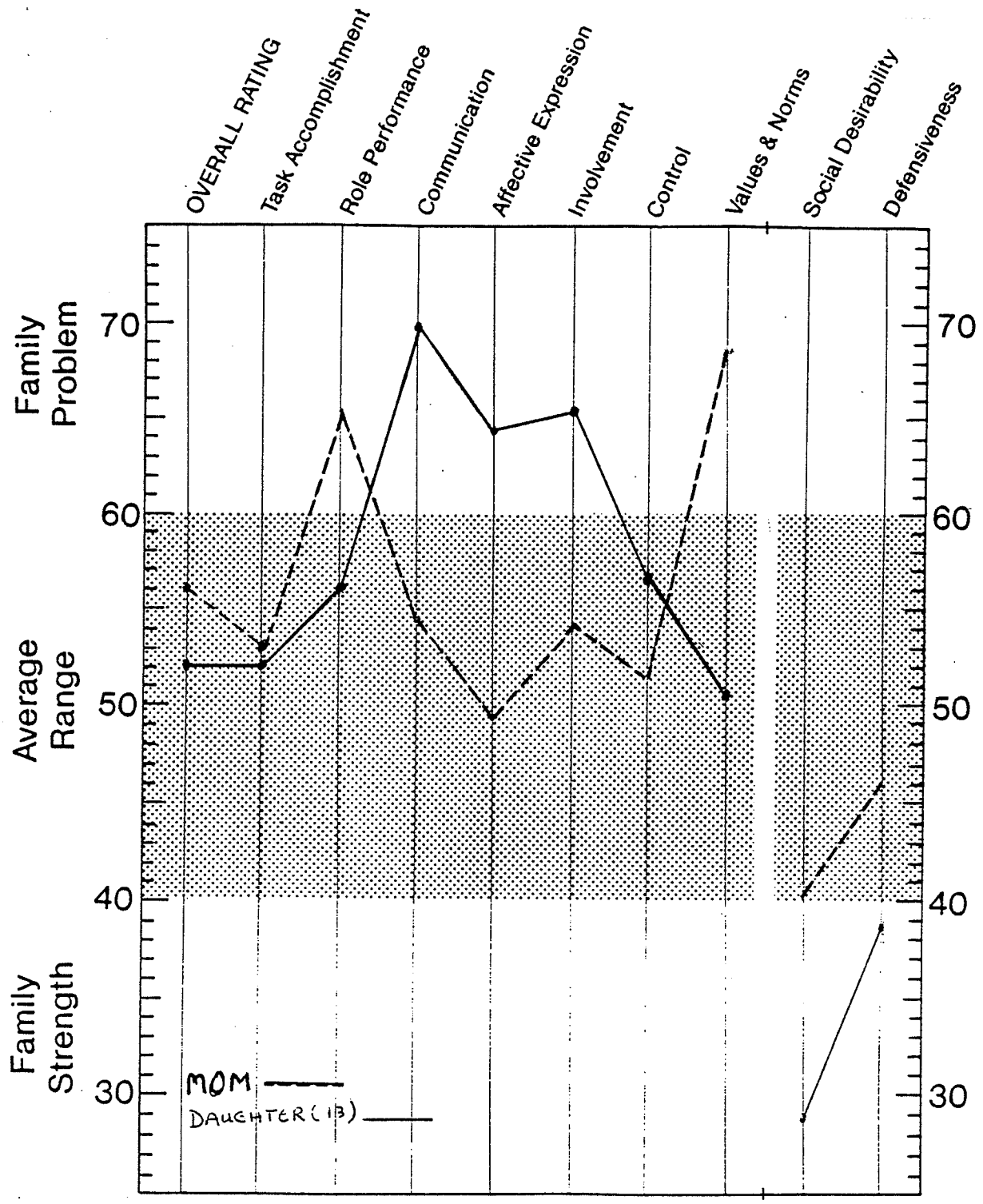
substantive changes especially on "role performance", and "values and norms" subscales. This is consistent with statements made in therapy about herself and the family.

The daughter's scores are considerably elevated on all subscales of the post scores, except for the clustering of scores on the control subscale. These elevated scores indicate significant difficulty. However, Sally's scores on "social desirability", and "defensiveness" subscales indicate anxiety and potential inflation of scores on the FAM III subscales. Therefore, caution needs to be exercised in interpreting Sally's scores. Her post scores on "social desirability" and "defensiveness" subscales indicate less anxiety about the family situation but still indicate concern about the family situation. Both parents had voiced their concern for Sally, expressing that she had not been paid attention to because of the constant concerns of Jim.

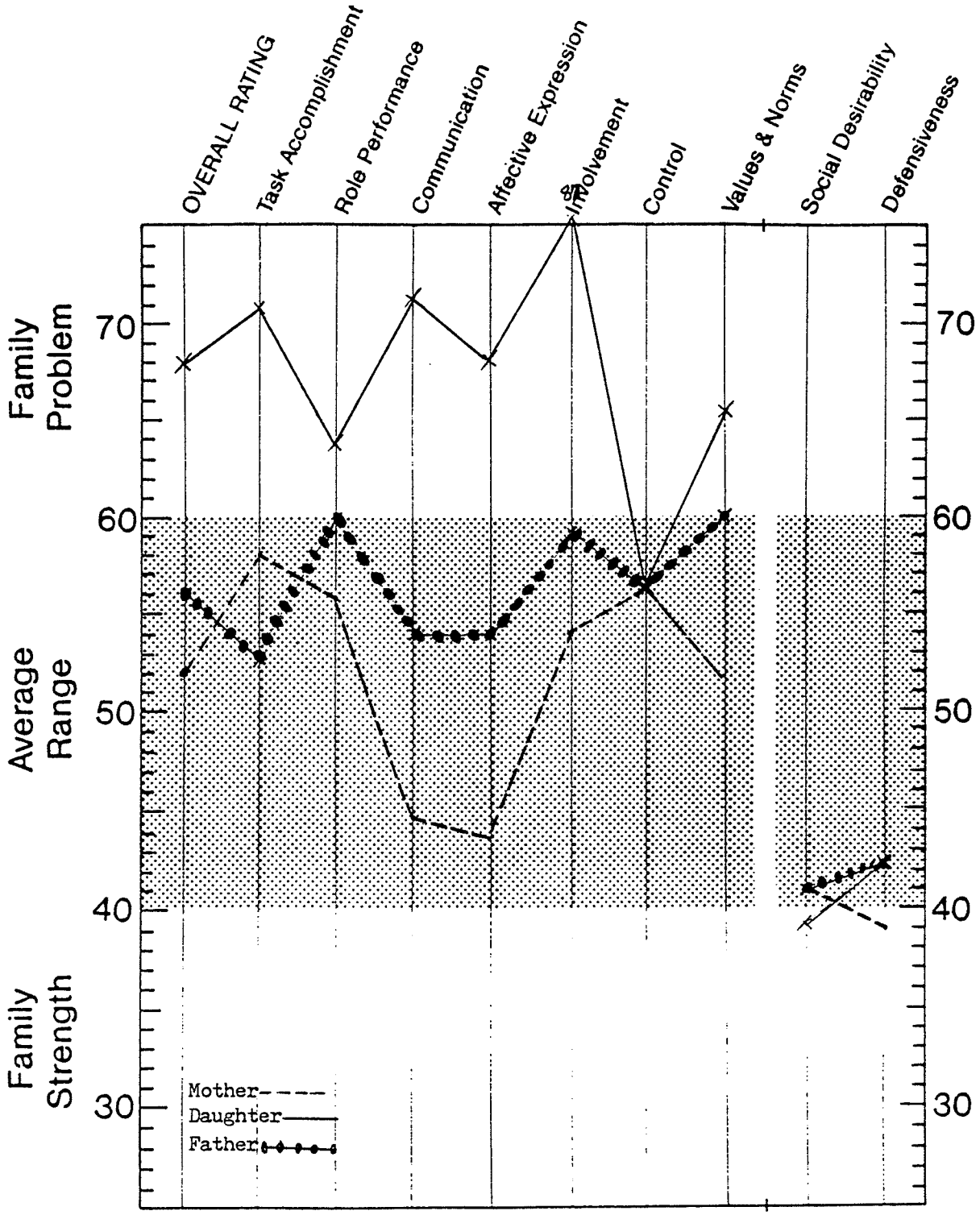
Father's post profile is interesting in that it closely mirrors mother's profile but his profile is difficult to comment on as there is not a pre profile to compare to. As well, it is important to note that despite initial reluctance on father's part to attend, he participated in sessions and completed the post FAM measure.

The clustering of mother's, father's, and daughter's post profile on the control subscale could be an ideal area to pursue if the family agree to resume therapy during the follow-up contact.

PRE THERAPY PROFILE - BOYD FAMILY
FAM GENERAL SCALE



POST THERAPY PROFILE - BOYD FAMILY
FAM GENERAL SCALE



The Taylor Family: Assessment

Previous and Presenting History

Mark (age 15 and in grade 9), has had a long history with the medical profession. From an early age Mark has had medical problems. These problems are described as epilepsy, blood platelet disorder, asthma, learning disability and migraines. Mark has not had medication for three years.

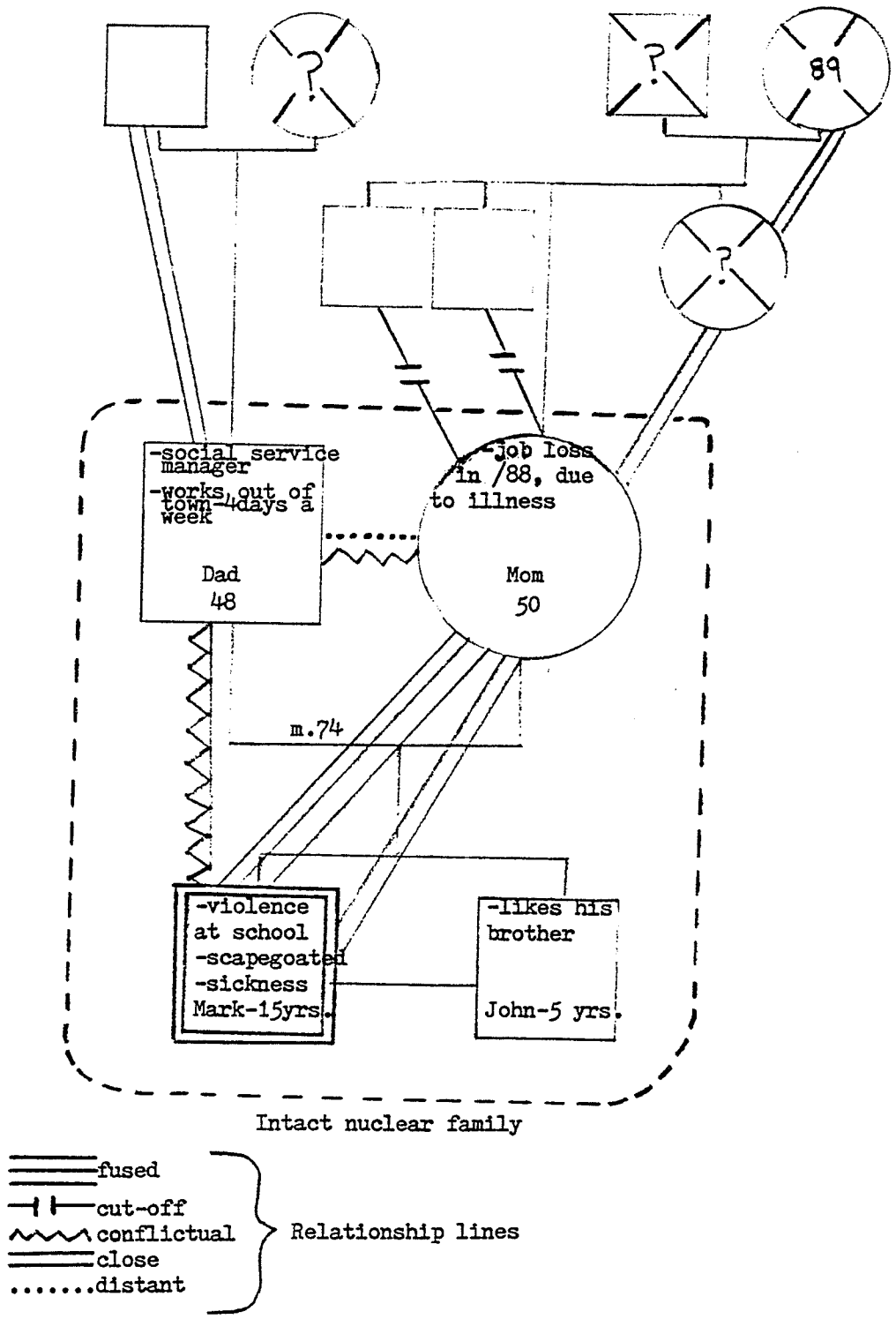
Three years ago Mom (age 50, and homemaker) gave up her nursing job due to a painful illness, initially caused by infection from impacted teeth. She has been to specialists in Toronto and Rochester, and continues to be in pain.

Dad (age 48) is away from home four days per week at a job in a community one and one half hours away. He is in a management position in a social service agency. He acknowledges that he has hit his son but says it was on one occasion only.

A special education teacher made the referral due to concerns of Mark's aggressive behaviours at school. They believed Mark had been involved with Satanism. They were also concerned about Mark's apparent "personality change", describing him as once very passive and getting beaten up, and now aggressive and seeking revenge. Some confusion existed over who made the referral and for what purpose. This confusion wasn't clarified.

Before seeing this therapist, Mark had various interviews over a six week period with two different LWCDC intake workers and with the child welfare social worker. No contact had been made with the parents.

Genogram


?
?
89
?
-social service manager
-works out of town-4days a week
Dad
48
-job loss in /88, due to illness
Mom
50
m.74
-violence at school
-scapegoated
-sickness
Mark-15yrs.
-likes his brother
John-5 yrs.
Intact nuclear family
fused
cut-off
conflictual
close
.....distant
Relationship lines

Family's Description of the Problem.

When the therapist called to invite the family in, Mom relayed that she felt deceived by the school. She said she didn't know that the school had made the referral. She requested that confidentiality on the part of the therapist be maintained.

Mom believed that Mark's violence (hitting and pushing), was unacceptable. She said Mark's violence at school was Mark's response to kids knocking him unconscious. She believed the school to be irresponsible in their dealings with Mark.

Dad felt that Mark had no life skills and little self-esteem. Dad believed that differences in values have created the conflict between him and Mark.

Mark declared he didn't know what the problem was but did concede his fighting was a problem.

Attempted Solutions

Mom protects Mark from life-threatening situations. She feels unsupported by Dad and believes she makes all the decisions in regard to Mark. Mark blames Dad, and Dad threatens to "bail out".

Communication and Interaction Styles

Mom talks for her son, having assumed a role of 'responsibility' blaming Dad for how the family is functioning. The collusion between her and Mark keeps Dad out. The parents, especially Mom, communicate to each other thru Mark.

Mark expresses his anger directly to Dad and Mark refuses to co-operate with his Dad. Mark feels scapegoated and not accepted by his Dad and by his peers. Mark helps Mom out when she is sick, usually when Dad is out of town. Mark speaks of wanting to "bail

out".

Dad is the most direct in the family. He has authority but is unsure as to how to go forward with it. He blames himself and Mom for the problems the family is experiencing.

Conflict

The parents avoid each other. Conflict is expressed directly by Mark. He seems to have given up on Dad.

Affect

Dad expresses hopelessness about his son, and vulnerability with Mom. Mom is rational and is mostly serious. She is polite, empathetic and protective of Mark.

Mark is openly hostile towards Dad and pessimistic about Dad's involvement. Mark's suspiciousness and anger mask his hurt.

Family activities are around illnesses.

Family Structure

Dad is uninvolved and dismisses himself, but he has authority. He pays the bills. He tries to do things with Mark but has been shut out by him.

Mom is the "expert" in regard to Mark, and Mark's illnesses. Their illnesses connect them, as Mark does things for Mom when she's not well.

Mark and Mom are enmeshed. Mark is the 'victim' both inside and outside the family.

Pertinent Family-of-Origin Information

Dad was the only child. His identification of what he would like for his son are based on his positive experiences of growing up (i.e., sports involvement, working, summer job and career.) He cares

for his ailing father in a nearby community. This is the same community in which he works four days per week. Mom says he's chasing a 'pipe dream.'

Mom, the youngest of two brothers, describes being cut off from them. She also had one sister (who was disabled). This sister is now deceased. Her parents are deceased. Mike is described as close to his maternal grandmother and maternal uncle up until age 12. At that time, the maternal grandmother died, and left her estate to the three children. They are apparently fighting over the estate.

External Sources of Stress and Support

Mark, and Mom especially, have very little outside involvement. The family is financially over-extended, as Dad supports two households.

Recent Family Crisis or Extended Family Crisis

This family have experienced a number of recent and extended crisis. They are: Mother's and son's chronic illnesses; mother's resulting job loss four years ago; Mother's increased physical symptoms (the infection has spread throughout her body). She receives treatment but is in continual pain. Dad's forced job loss one and half years ago, and subsequent new job and move, are other demands place upon the family.

Hypotheses

Mark's acting out requires the school's involvement with a parent. The mother is called and she in turn involves father (according to her decreased physical capacity). Father accompanies mother to the school meetings, and he attempts to do things with his son.

Mark's fights protect Mom and Dad from dealing with each other

directly; he sacrifices himself for the parents, which keeps him from learning lessons from each parent, which is what he needs to do in order to grow up and leave home.

Therapeutic Goals

The therapist had established three goals in which to intervene. They are: to increase the father's involvement, to loosen the mother's and son's enmeshed connection, and to strengthen the parental connection.

Proposed Treatment

The therapist proposed the following three approaches and interventions for reaching the above identified goals. The first approach used the notion of separateness and differences between Mom and son, and pushed for individual expression of these. The notions of separateness and differences were used to change Mom's idea of togetherness. In the second approach family members were helped to get past blaming of each other by examining their relationships. The parents relationship, was processed so that differences could be expressed. The third approach responded to the first and second approaches, blocked Mark's moves to support Mom. Blocking Mark's supportive moves was done by examining the dyads. For example, various questions were asked to give family members new information about their patterns of behaving. Some of these questions were: "Would the system (Mom) allow Dad to take care of her?"; "Would the system (Mark) allow Dad to take care of him?"; "Who takes care of Dad?"; and, "Would Dad have to be sick to be taken care of?". Specific questions asked of the father and son dyad explored differences between them, and focused on their view of what its like to be a kid. Similarities and differences of their "vision" were compared and contrasted.

Evaluation of Use of Circular Questioning

Therapeutically, circular questioning is valuable as family members do not experience being blamed by the therapist. Members respond quickly to this type of questioning. For example, Dad expresses that he has heard some new things from his wife and son. He says this has been helpful, to a point. Mom expressed feeling better seeing Dad and Mark beginning to connect. Mark made some implications that he still held out some hope for Dad.

More practice and experience are needed in order to gain competence in the timing and selection of types of circular questions.

Further Intervention, Assessment and Evaluation

Precipitation of a crisis at the school, ended therapy. Mark had gotten into a fight at school, and the school required Mark have a psychiatric evaluation before allowing him to return. The parents sought out a psychiatrist in Winnipeg recommended by Mark's regular doctor. The parents asked that the therapist not become involved with the school. They considered having Mark change schools during this period. Although it was understood that the family wanted to continue in therapy, planned sessions were cancelled. Mother made several phone calls and another family session was scheduled. No one showed or called for this last session. One final call was made to Mother. The therapist and Mother spoke of a referral to the local hospital, to a colleague who is knowledgeable about chronic pain. The therapist and mother also spoke about marital therapy. Mother indicated she would call to reschedule, but did not. It is unclear what information mother relayed to father and son. Unfortunately,

no further contacts were made or received. This lack of closure was unsatisfactory to the therapist.

In reflection, initial questions about "problem definition" may have more fully explored the family's position in regard to the school. In later sessions Mark described the school as being the "winner" and himself the "loser". Mark expressed the feeling that changing schools meant that the school "wins", twice. Mark also stated that he had received messages from different teachers in regard to the decision (i.e., psychiatric referral) the principal had made. He perceived that these teachers had taken his side. He states the teachers made the following statements: "You defended yourself, I'll stand by you"; "The principal's brain is fried"; and, "The principal is losing it".

Given that the family was referred by the school, and given Mom was adamant about the therapist not being in contact with the school, these may have been contraindications for the family and therapist to continue in the way that they did. The therapist did not pay enough attention to the symptom perpetuated by dysfunctional relational patterns which extended beyond the family and included the school. A session including the parents and the school previous to engaging the family for the purpose of family therapy, may have, at the least, given the therapist direct access and information from the school.

Pre/Post Therapy Profile

Family members completed the pre measure during the first session and the post measure at the end of the fourth session - approximately two months later. Mom did not attend the second session, one session was cancelled, and no one showed or called for one session (a total of six planned sessions).

Mom's and Dad's scores reflect their anxiety about the family situation as demonstrated on the "social desirability" and "defensiveness" subscales. Their scores will be artificially elevated. Mom's scores are elevated higher than Dad's on task accomplishment, role performance, communication, involvement, control, and values and norms subscales. Her post scores on "social desirability" and "defensiveness" subscales show she remains anxious and reflect her view that the family needs help. Mom has reversed her position on "communication" and "involvement" subscales from her pre to post scores. A possible explanation for this reversal is her satisfaction of Dad's and son's improvement in their relationship.

Son's scores are elevated on task accomplishment, involvement, and control subscales. He and Dad intersect on the "role performance" subscale. There are some mirror effects on communication, affective expression, involvement, control, and values and norms subscales.

Dad's scores significantly drop on the post measures, although the task accomplishment subscale still remains elevated. Differences between Mom's and Dad's scores on the "task accomplishment" subscale could be reflective of their respective roles. That is, Dad pays the bills and expects that Mom will take care of household duties. Mom, on the other hand, expects help with parenting in the form of Dad's support in decision making.

The changes in these scores are a puzzle. However, it seems that Father and son are aligned much closer than originally thought. This may have been demonstrated during the second session when Father and son participated without Mom. It was explained that Mom was too sick to attend. During the second session a significant change in the tone of interview was apparent. The hostility between Father and son had evaporated. Each were openly communicating without

blaming, and with little involvement by the therapist. In the third session, Mother stated that she felt Father and son needed some time without her.

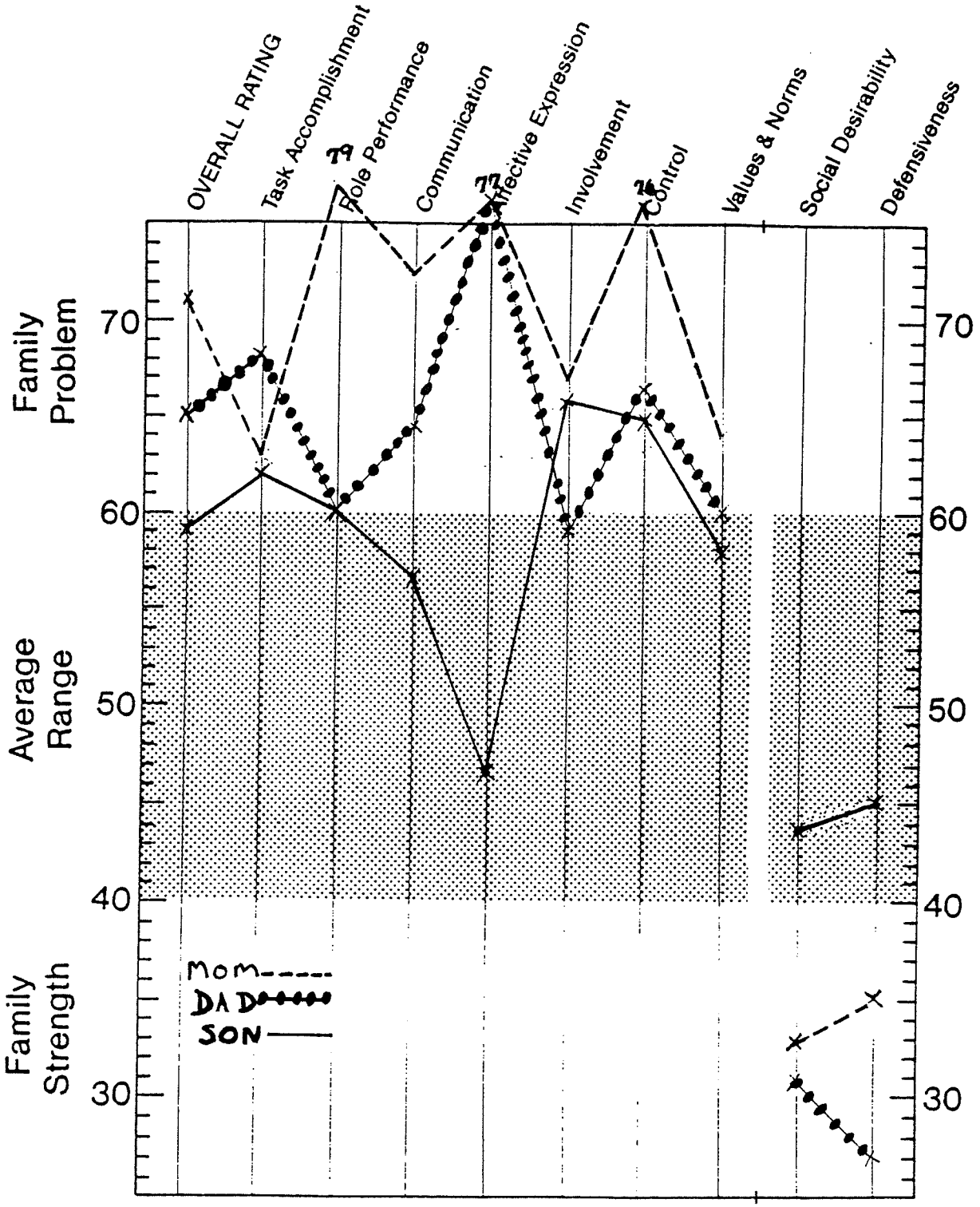
Change in Father's scores may indicate he had made a decision, perhaps, about his involvement with his son or his wife. This remains unclear, as the therapist did not have an opportunity to explore this.

The therapist did not have experience with people in chronic pain. Consideration of Mom's scores could be reflective of her degree of emotional pain, and perhaps of a combination of her physical and emotional pain. The therapist overlooked the possible significance of this combination and degree of the Mother's emotional and physical pain.

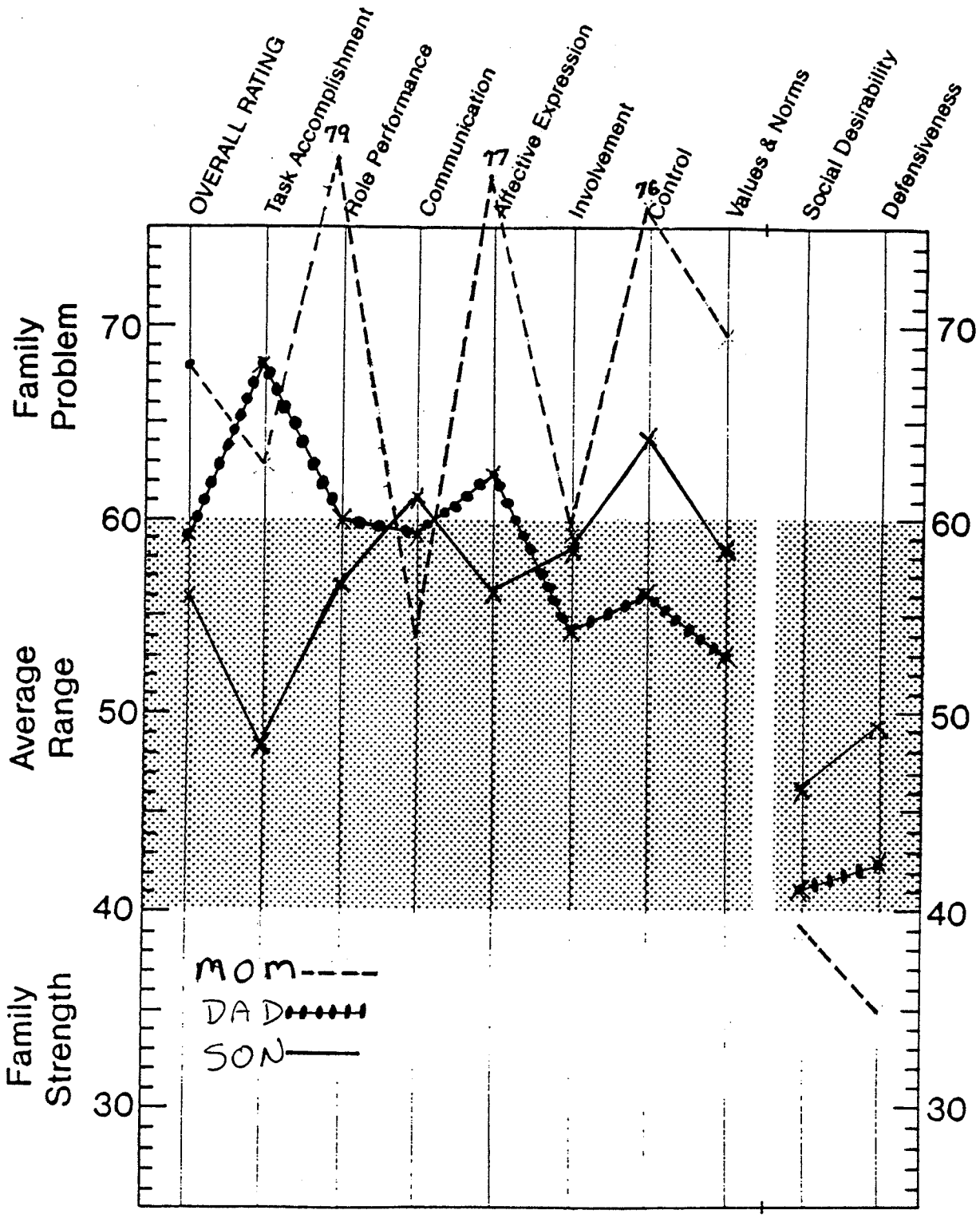
With the discrepancies between Mother's and Father's scores, one could assume their marital difficulties were significant. Dad indicated so directly, but Mom did not.

PRE THERAPY PROFILE - TAYLOR FAMILY

FAM GENERAL SCALE



POST THERAPY PROFILE - TAYLOR FAMILY
FAM GENERAL SCALE



Robb Family: Assessment

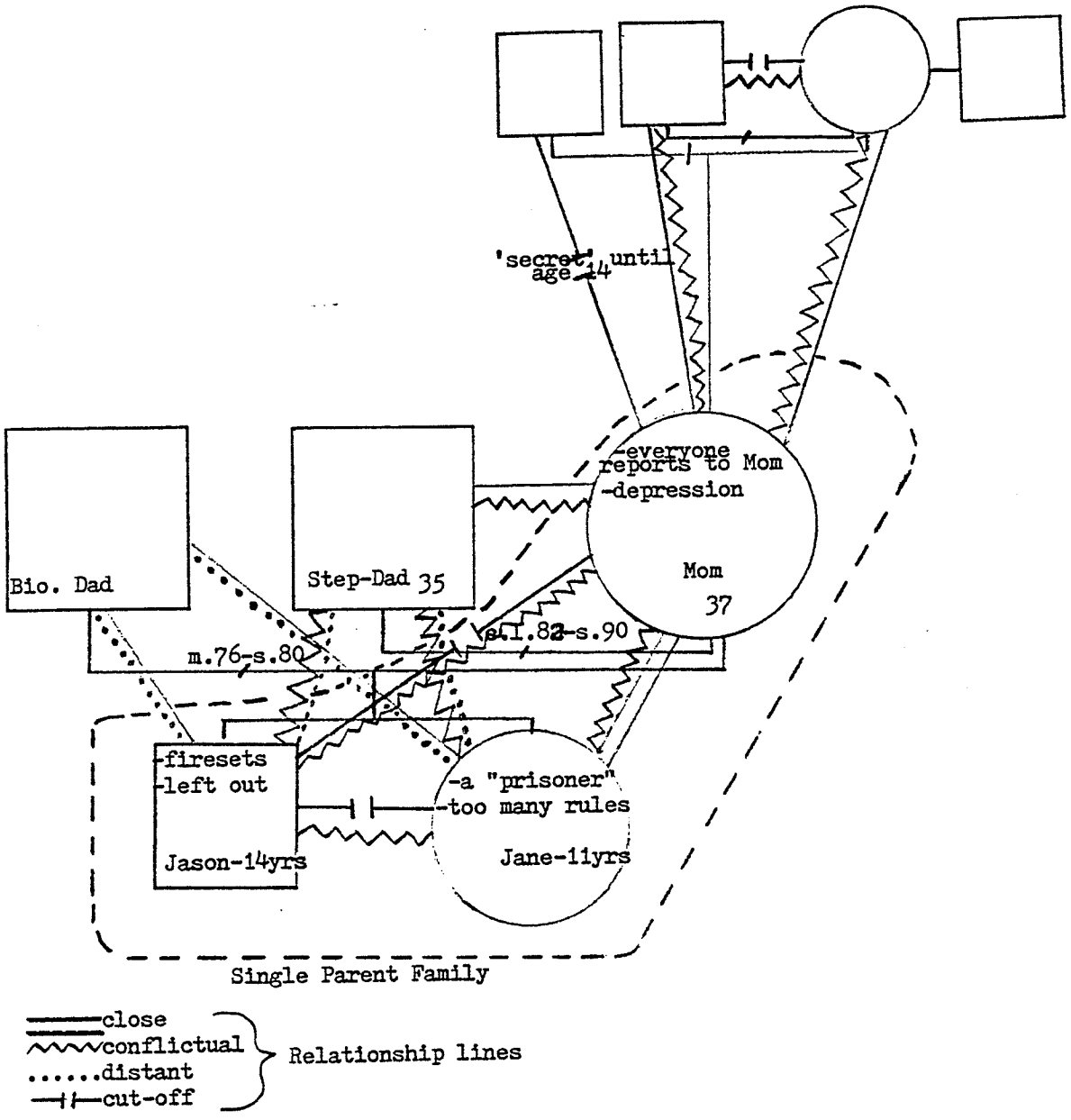
Previous and Presenting History

Mother and children had previously been involved with the LWCDC. She and her common-law partner were experiencing step-parenting difficulties. At that time, her partner did not attend. The children and Mom were seen individually, and all family members were seen together.

During Mom's first marriage, the biological Father sexually abused his two children, Jason (at age 4), and Jane (at age 1). He was incarcerated. Mom left this relationship when she realized her husband had abused other children as well. She states she still loves him. Jane has no memory of the abuse. Jason romanticizes the family that is lost, blames his Mother and is angry towards her for this loss.

Three weeks prior to making this referral Mom had separated from her common-law partner of ten years. Jason and Jane describe Mom as threatening them with attending counselling or going to Children's Aid. Jason and Jane say that they are glad their step-father is out of the picture. Mom describes a recent course she took in "systemic training for effective parenting program", as being helpful. She realized she had not failed as a parent, and she realized that other people have problems with their kids too.

Genogram


'secret' until age 14
-everyone reports to Mom
-depression
Mom
37
Bio. Dad
Step-Dad 35
m.76-s.80
m.82-s.90
-firesets
-left out
Jason-14yrs
-a "prisoner"
-too many rules
Jane-11yrs
Single Parent Family
close
conflictual
.....distant
cut-off
Relationship lines

Family's Description of the Problem

Mom described her long-standing concerns in regard to Jason (now age 14), and Jane(now age 11). They are hostile, angry and do not listen. Mom wants them to be responsible.

Jason is in grade 8, and has an A average. He has friends, participated in school activities and worked part-time. Jason described his need for space from Mom and Jane, and he wants more from Mom.

Jane described that living in her home as 'being like a prisoner' where Mom is the jailer. She stated that there are too many rules and she doesn't know why. Jane is scared to be at the LWCDC because of Mom's threats of placement in Children's Aid. Jane wants to be able to ride her bike to school. She feels picked on by the family. Jane doesn't like her Mom constantly checking up on her. Jane believed nothing will change even if she listened to Mom.

Everyone is described as reporting on each other to Mom. Mom acknowledged being angry with Jane and withheld affection from her. She says she knows this is wrong, but has been unable to stop. Mom described having to 'be nice' to the step-father.

Attempted Solutions

Mom states she has tried "everything written" and "things she's heard about". She involved outsiders help (i.e., school personnel, fire chief, and the child welfare-social worker). She blamed and criticized these outsiders.

Communication and Interaction Styles

Blaming and control bind up all family members so that they are helpless. People cannot be competent in this system as Mom tried to make people always do the 'right' thing. Communications are

vague, uncertain and indirect.

Mom is the expert, the super-responsible one with knowledge. She is in charge and makes all the rules, expecting everyone to conform to her expectations without question. She wants to be a good mother, described "mothering" as her job, and has little interest in outside activities of her own. Her communication is confusing, as she expects Jason and Jane to be responsible but provides few opportunities for them to make their own choices.

Jason believed he's doing okay at home and at school. He doesn't believe he should be blackmailed by his Mom to attend sessions at LWCDC and stated he does not want to attend. Jason described arguing with Mom as "okay" because arguing is a way to compromise. He will compliment Jane when he wants to, not because he's told to.

Jason doesn't like expressing his anger directly toward Mom. He lit a fire on one occasion, and has waved a knife at Jane. Mom reports that Jason pushed her on one occassion.

Family Structure

Intense loyalty exists between Jason, Jane and Mom, which Mom continually pushes for.

Hypotheses

The children show their caring by acting out and creating many opportunities for Mom to be a parent, as they know how important this is to her. These behaviours keep all family members close, as Mom highly values family togetherness.

Pertinent Family -of- Origin Information

Mom described living with her parents an emotionally abusive experience. When she left home at eighteen, so did her mother. At age fourteen, she accidently discovered that the person she thought was her father, was her step-father.

Therapeutic Goals

The three goals of therapy were to: first, increase space between mother and daughter; second, develop clearer boundaries between all family members; and third, to develop themes to make patterns of family involvement more overt.

Proposed Treatment

To reach the therapeutic goals as stated, the following approaches were proposed. First, increasing space between Mom and children involved: Mom needing to be more independent; decreasing her focus on the children; and increasing her differentiation from her family of origin. Second, developing clearer boundaries between all family members involved: looking for enmeshment patterns, pointing out these patterns, and predicting responses. Third, themes chosen to make family involvement more overt: distance and closeness of family members (i.e., bind in issues of responsibility, tasks and rules); and communication between family members (i.e., decrease people talking for one another, and increase communication by focusing on family members expression of affection for each other).

Evaluation of Use of Paradoxical Intervention

Mom responded angrily to the paradoxical letter (see appendix B). Mom directly expressed her anger toward the therapist in the session. She felt the letter was simple and irrelevant. She also reminded the therapist of a list of other problems. Family members did not read the letter together as instructed. Mom read the letter

and gave it to Jane to read. She had not shared the letter with Jason.

During this session Jane expressed her anger toward Mom, directly and appropriately. Mom told me later that she realized that Jane's anger was Jane's own. Their relationship steadily improved after this point. Jason became the focus of attention at this point, although Mom still identified concerns she had about Jane.

The therapist hadn't expected Mom's anger in response to the letter. Since Mother's rule was not to express anger, this opportunity allowed Mom to safely vent her concerns as the therapist listened, and validated Mom. This exchange between Mom and therapist was observed by Jason and Jane. This situation may have been helpful to Jane who expressed her anger directly to Mom during the session. Subsequently, Mom responded appropriately to her daughter, and stated her new understanding of their relationship.

Putting an intervention in writing is an appealing one. It forces the therapist to put relational patterns in black and white. This letter provided an opportunity for distancing and reflection. As well, a therapeutic letter is an unexpected informal and formal way of communicating with all family members. Care must be taken to compose letters that reflect family patterns which have been discussed and processed during family sessions.

Further Intervention, Assessment and Evaluation

After the session in which the paradoxical letter was discussed, Mom requested individual sessions for herself. Jason had adamantly stated he did not want to be in therapy at this time, and Mom wanted Jason and Jane to have a summer break. A decision was made to suspend family sessions at this time. During this break the family was encouraged to discuss the letter together, and to discuss people's interpretation of the letter. Mom requested to be seen

individually.

During individual sessions, Mom disclosed new issues of her own. These issues included her struggle to differentiate herself from her parents. She expressed feelings of being unable to please them, feelings of rejection and lack of acceptance. She indicated that she wasn't ready to deal with issues regarding her mother. Other issues included: gynecological problems which affected her mental health; eating problems which she called an "addiction"; an affair, while living with her common-law partner; the partner with whom she had had the affair was dying, and he had asked her to keep this a secret; her children had met her partner with whom she had had the affair but were not told of the relationship between them; and her role as the "responsible" one, which she was struggling with. She stated it was easier to focus on others because when she focused on herself she experienced being depressed.

Individual sessions with Mom focused on barriers constraining her from making choices. A sense of competence and being worthwhile was encouraged. Some of the barriers as defined by Mom were: her isolation of details of specific issues which exhausted her; her defending and justifying herself to everyone; identification of internal and external voices which got in the way of making changes; identification of criticisms described as a long "tunnel" and "brick wall" which kept her stuck; her fearfulness of making choices because these choices seemed to be mistakes; and her role as the "responsible" one for everyone.

During final individual sessions, Mom discussed a number of decisions she had made for herself. These were to attend a woman's self-help program, to learn to drive, and to get out more on her own. She described herself as being more relaxed and as having more energy. She also said that the children were having a good summer.

After this loosening-up period where family members were

relating to each other in more flexible ways, Mom began to "pull in the reins". She again wanted the children to be seen and pushed for this. The family attended sessions, although Jason and Jane stated they did not want to be attending. During these sessions family members were encouraged to speak separately. Members were asked what each would be doing five years from now. Jason expressed that he would be gone from home and he would be attending university. Jane expressed that nothing would have changed. Mom stated that Jason and Jane would be happier. During these sessions, less talking and interpretations were being made for each other by family members. The therapist focused on communications about tasks and the motives expressed. It was described how Jane takes over for Jason when he doesn't do his chores (i.e., setting table, loading dishwasher, going to the store, paper route). When he sleeps in or neglects bath-time, Mom is after him and she tries to control when and how his responsibilities are to be accomplished. It seems family members take over for each other as if they're not responsible. Much bickering and talking between members takes place in this way. The function of this bickering is to keep all family members close. Jason and Jane want some distance because there is too much closeness. Jason's and Jane's behaviours threaten the closeness that Mom wants. Jason's and Jane's behaviours challenge family rules. These rules are: if people are nice (i.e., being good by listening) they get loved; and if you conform to the expectations of being together in a way in which no differences are expressed, then family members can relate to each other.

At this time Jason stated he absolutely would not continue. He was going into grade nine, and continuing at LWCDC was not on his list of things to do for the next year. No further family sessions were held, although the family were left with the option of

continuing as a family at some later date.

Mom continued in therapy after the completion of the practicum. She requested continuing work in regard to her personal issues, and to her issues of parenting.

Pre/Post Therapy Profile

Scores are significantly elevated for all family members on both the pre and post therapy profiles. All family member scores on "social desirability" and "defensiveness" scales reflect high anxiety and potential inflation of scores on FAM III subscales. Therefore, interpretation of mother's and daughter's scores should be made cautiously on pre profile, and interpretation of all family members scores should be made cautiously on FAM III post profile.

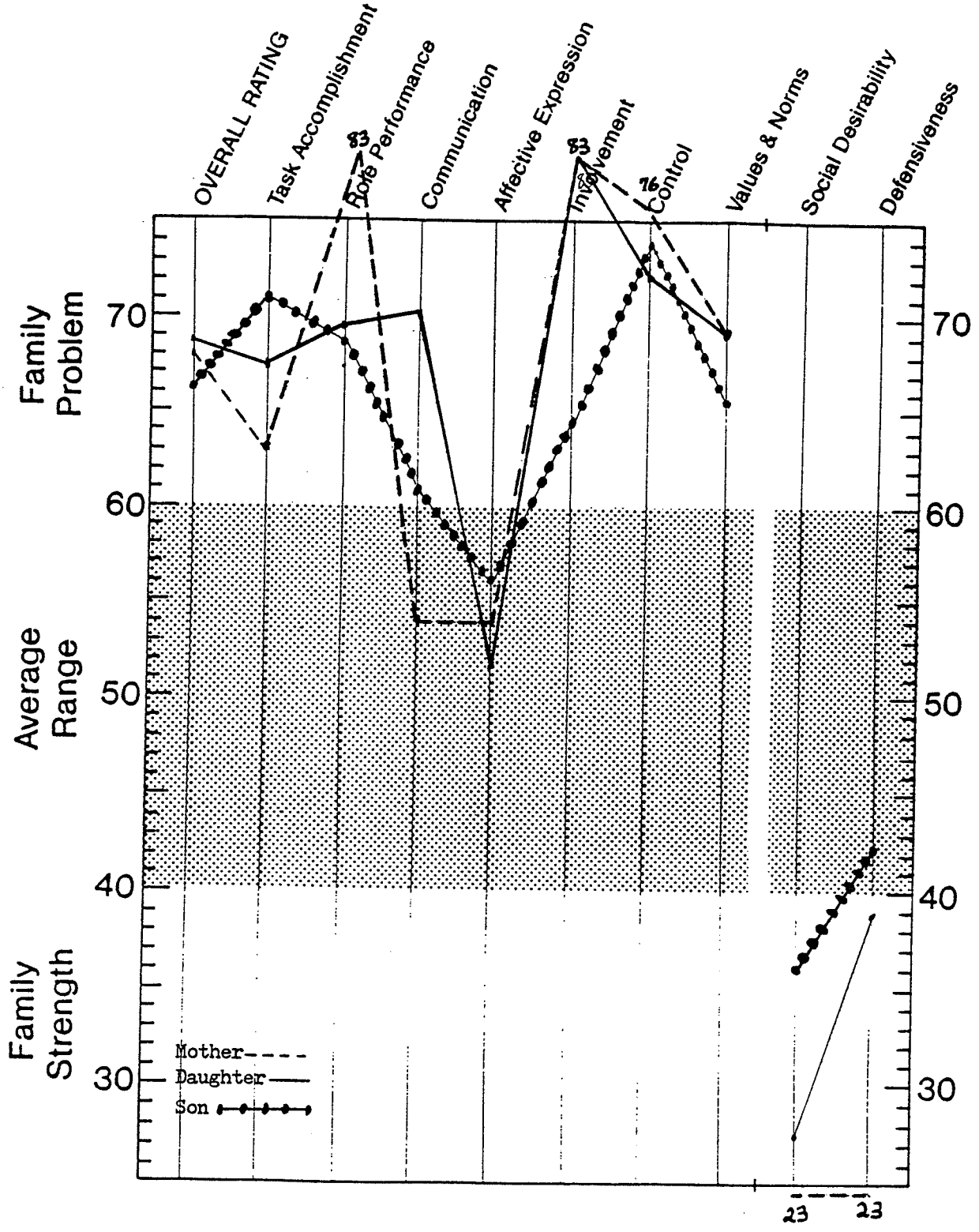
Jason and Jane's scores got worse from the pre to post profiles on "communication" and "affective expression" scales. A possible explanation would be their reluctance to attend, given the choice which their Mother had given them (that is, attend counseling or go to Children's Aid). Jason's scores improved on "control" scale, perhaps in response to Mother's decreased score on the same scale.

Post therapy scores were obtained at 3 month intervals. At the six month interval no scores were obtained. During this six month period there were eight family sessions, six individual sessions with Mother, and one Mother and daughter session.

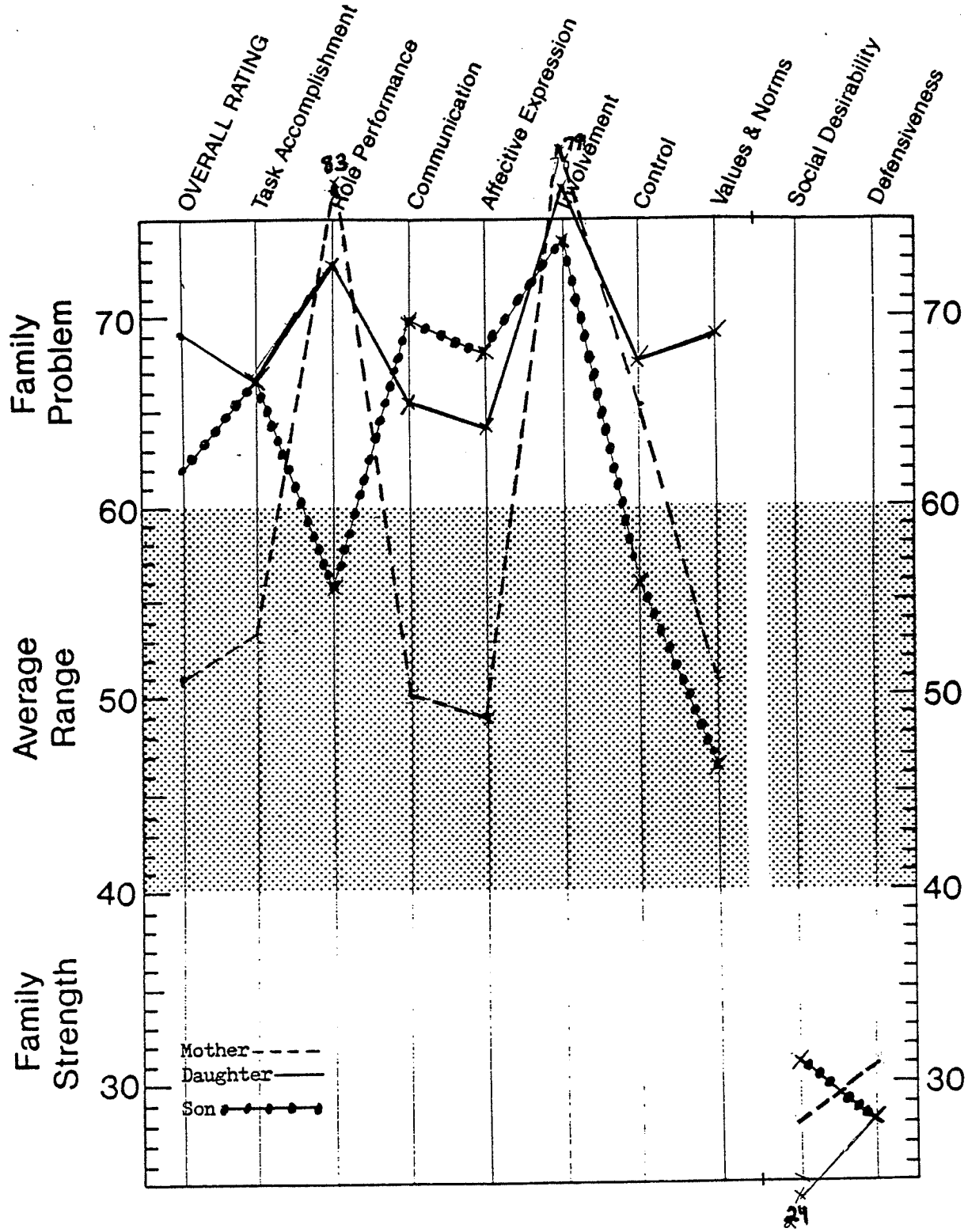
Although post scores remain elevated, some spread between them may be indicative of the period of "loosening" as reported by family members. Mother's high scores on role performance, involvement and control subscales may indicate her high degree of anxiety.

PRE THERAPY PROFILE - ROBB FAMILY

FAM GENERAL SCALE



POST THERAPY PROFILE - ROBB FAMILY
FAM GENERAL SCALE



CHAPTER FIVE

Evaluation of Therapist by Clinical Supervisor

The clinical supervisor evaluated the therapist in the form of weekly supervision, group supervision and use of the Family Therapist Rating Scale (FTRS). Supervision focused on interaction between the therapist and family. Specifically, supervision addressed the therapist's assessment of the family; and intervention(s) used by the therapist. The therapist recorded experiences and issues of clinical practice in a log.

Individual Supervision

The therapist met with the clinical supervisor on a weekly basis for supervision. Each supervisory session involved meeting for approximately one and a half hours. Initially, audiovideotapes of family sessions provided the basis for case discussion. The therapist found viewing audiovideotapes time-consuming, so live supervision replaced audiovideotapes. The therapist considered live supervision to be more effective and efficient. The therapist realized that the supervisor intervenes with the therapist, just as the therapist intervenes with the family.

Group Supervision

The therapist attended weekly group supervision for approximately three and a half hours with group members who were also being supervised. During this time the therapist or various group members would participate in live supervision. Live supervision involved use of the one-way mirror and telephone. The clinical supervisor and group members provided feedback aimed at intervening with the therapist who was involved with a family.

The therapist found group supervision to be a time of high energy and excitement. A feeling of 'shared responsibility' and 'unlimited options' permeated this time. A highlight for this therapist during the six month practicum was the participation and supervision by the academic advisor, and the participation of a social work student on field placement. The addition, even briefly, of two new members to the group process was a bonus to this therapist's learning and experience.

Family Therapist Rating Scale

Use of the Family Therapist Rating Scale was motivated by the desire to specifically evaluate and measure observed behaviours of the therapist's therapeutic skill. Two of the five skill categories of this rating scale were rated. They are: structuring behaviours and relationship behaviours. Structuring and relationship behaviours are considered to be two basic sets of skills necessary for the family therapist. Ten items in each category describe effective and ineffective behaviours. Each behaviour is rated on a seven point scale. The results of the behaviours rated were given to the therapist after the conclusion of the practicum.

Description of Implementing the Family Therapist Rating Scale

At the beginning of the practicum, the clinical supervisor rated the therapist during the initial three sessions with three different families.. At the end of the practicum, another rating of therapist skills during the final three sessions with three different families, was taken.

Mean ratings of those behaviours observed within each category, were placed on the profile. These pre and post ratings are demonstrated in the Family Therapist Rating Scale Profile.

FAMILY THERAPIST RATING SCALE PROFILE

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

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

Structuring Behaviors

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

Relationship Behaviors

1. Engenders hope.
2. Uses self-disclosure.
3. Demonstrates warmth.
4. "Communicates" the attitude that the client's problem is of real importance.
5. Tone of voice conveys sensitivity to the client's feelings.
6. Speaks at a comfortable pace.
7. Empathizes with family members.
8. Confirms family members experience of an event.
9. Attempts to improve the self-esteem of individual family members.
10. Demonstrates a good sense of humor.

PRE ----
POST——

Pre/Post Family Therapist Rating Scale Profile

Overall the therapist improved in most areas, both in structuring behaviours and especially in relationship behaviours. These changes are reflective of the therapist's struggle in developing a systemic understanding. Continuing to learn to use structural and relational behaviours, in terms of the family as opposed to the individual, represents a major shift in thinking. As the therapist matures, use of structural and relational skills will become more integrated. This continual integration of skills will move the therapist away from an "either/or" position. This position is demonstrated by the greater change in relational skill development which took place. The therapist focused mainly on relationship behaviours for the engagement of all members of the family. The therapist was indirectly aware of focusing on relational behaviours for the purposes of the practicum. In reflection, it is clear both structuring and relationship behaviours must simultaneously be utilized in processes of engagement and joining of the family.

Time and experience are needed by the therapist to develop a unique style. This style will reflect decisions made in management of tasks necessary in therapist development. Information provided by the FTRS in which no change was noted, provides a specific area which the therapist can learn from. For example, the sixth item of structuring behaviours, namely helps clients rephrase "why" questions into statements, would be developed. However, no change in the skill category of relationship behaviours, namely "uses self-disclosure", was noted. The therapist had used self-disclosure in other interviews not observed and therefore not rated by the supervisor.

A decrease noted in the skill category of structuring behaviours, namely "makes a brief introductory statement about the purpose of the interview", reflects the therapist's omitting a basic task given the concentration on other tasks.

The FTRS profile was helpful in identifying therapist improvement. The scale also provided a clear indication of important skills the therapist was either not using, had forgotten to use or was yet to learn to use.

Evaluation of Use of Family Therapist Rating Scale

These results will prove to be useful for the therapist in further enhancement and development of basic skills in all categories of the FTRS. These categories provide simple and clear guidelines to the therapist wanting to further develop and strengthen clinical skills. Since each category is representive of a particular model of family therapy, the use of this scale would assist in developing a broad base of clinical skills from a variety of models.

This scale is valuable for therapist, supervisor or trainer use. It is easy to use, and takes little time to complete as the rater does not have to rate every therapist movement or word. Completion of the scale clearly shows therapist skills and behaviours which are 'maximally effective' and those 'not present'.

Therapist Log - The Experience

A log was kept to record the experiences and issues of clinical practice during the practicum. Information recorded in this log was of a personal nature, and reflected the therapist's recognition and acknowledgement of the complexities of considering 'family plus therapist'.

Recognition and acknowledgement of 'family plus therapist' meant dropping the pretense of objectivity, and has been another turning point for this therapist. Acceptance of limitations, including anxieties and insecurities, meant a clearer focus could be developed.

However, this focus means further exploration on the therapist's part. Therefore, development of professional identity and style will continue in the form of individual and group supervision. These forms of supervision provide a balance and an opportunity to integrate several needs. These needs are: the continued need for independence, autonomy, and structure; and the need for opportunities to be creative, spontaneous and explorative. Continued therapist development will incorporate various family models, and will integrate knowledge about working systemically with families.

Participation in supervision on an individual or a group basis allows for opportunities to listen to colleagues who are experiencing various similar and different processes. This opportunity to listen to colleagues share their experiences and interventions is a rare one, which provides invaluable information.

Summary

It is essential for the family practitioner to participate in individual and/or group supervision, in order to drop the pretense of objectivity. The process of supervision has highlighted the interaction of "therapist plus family", for this practitioner. Previous to the practicum this practitioner had not relied on the "experience" while in session with a family. The pre and post FTRS profile provided concrete and specific areas of therapist behaviours necessary for family practice. Structuring and relationship behaviours enhance the "experience" of "therapist plus family". The inclusion of all skill categories of the FTRS would continue to

enhance therapist development. These additional skills would accentuate a stance in which "family plus therapist" is the focus for consideration at all times.

CHAPTER SIX

Discussion and Conclusions

The experience of being involved in a six month family therapy practicum and the writing of the practicum paper was one filled with anxieties and insecurities. And now, in reflection, it can be called worthwhile and reassuring. These opportunities allowed further integration of family practice issues on a number of levels. These issues are incorporated into the three main focuses of the practicum. A summary of these focuses include: one, the family as a primary target for change; two, therapist development; and three, observations and experiences in the practitioner's place of employment.

Generally, exploration of the literature of conducting family therapy with adolescents found that little attention has been paid toward theory and methodology. Structural and strategic themes were rich with theory and interventions. Communication, developmental, historical and ecological themes provided specific theoretical information of value to the family practitioner. This information was specific to the family at the adolescent stage of the life cycle and included ways to help the parent and adolescent communicate more effectively. It also included parental and adolescent tasks, and crisis which occur at this stage. Family environment relationship patterns and the family with adolescents in the 'present day' concluded the literature review. Limitations of the review involved lack of specific information about culture and gender. Although these themes are alluded to in the literature review, their inclusion would further expand an understanding of the family at the adolescent stage of development.

Specifically, when considering the family as a primary target for change the practitioner noted the following considerations. The inclusion of all significant family members, with a focus on the present (i.e., what to do now), encourages the involvement of resources close to the adolescent who might not otherwise be available. The focus when doing family therapy needs to be on the adolescent and parents, so that the adolescent is released from the symptom before the therapist proceeds to marital work.

Understanding how the symptom will be eliminated, and what will happen if the symptom is eliminated, provides the practitioner with information useful in designing an appropriate and effective intervention. The ability to predict symptomatic behaviour provides a message to the family that the practitioner is in charge.

The practitioner's awareness of conflicting influences on the family and other situations i.e., hospitalization or institutionalization, must be developed so that counter-productive forces can be considered. The family can provide its own contra-indications to therapy when threats to leave the family are made. The practitioner needs to resolve the conflict or move the adolescent out of the conflict so that the therapist can continue more directly.

When particular problems like chronic illness or physical problems are presented, the issue for the practitioner is still to improve family functioning, given the particular symptoms.

Strategic methods are to be used sparingly in families with adolescents. These methods are to be used with families whose problems are less severe and chronic. Ideally, a goal in the use of strategic methods is to end the cycle in which the adolescent, by manifesting troublesome behaviour, stabilizes the family. Strategic methods offer some of many methods used to reorganize the family to survive change.

This practitioner's first experience with use of the FAM was positive. The FAM as a self-report measure proved useful. The completed profiles provided readily available information which was displayed visually for easy access. Even with the difficulties of obtaining pre and post measures from all family members, its use is recommended, particularly to provide a structured way of comparing differing information and perspectives between the family and therapist. Previous to the practicum, the practitioner had difficulties joining with both family and adolescent. New information and skill development has aided this practitioner's ability to join with both family and adolescent. Increased knowledge of the unique features of adolescence as a developmental phase in the family life cycle has been especially helpful. Recognition of issues of the adolescent, the parents, and often the family in relation to the community provides a new starting point. When symptoms of adolescent problems are recognized as signals that reflect family life cycle 'derailment' or 'stuckness', then it is more likely that the individual will not be pathologized.

The first contact usually establishes the practitioner and family relationship. An agreement or understanding must be developed between the practitioner and family so that the therapeutic process can take place. This may be difficult as families come in precariously. The practitioner's confidence, demonstrated by not rushing to problem solve or find a quick solution, provides a hopeful message to the family. Part of the understanding which is developed between the practitioner and family is identifying what specifically needs to be changed. Asking the family if or what change has occurred before therapy, and outside of therapy, again gives the practitioner important information. Asking particular types of questions gives messages to the family of their competence, and of expectations of their strengths.

A fluency in basic therapist skills enhances the position of the practitioner so a message of co-operation and respectfulness is conveyed to the family. Asking questions at the right time, the appropriate pace, and blending with the family is very useful.

Practitioner skill and experience need to be taken into consideration when using strategic methods. The beginning therapist may be able to proceed with strategic methods when supervised by a supervisor trained in strategic methods. Use of the team and supervision provides a milieu enabling the therapist to proceed with the family, while expanding their own development.

Just as the family at the adolescent stage of the family life cycle is in a 'paradoxical' situation so is the practitioner. Recognizing that the therapeutic procedure has an inherent 'paradox', allowed the therapist to slow down. Slowing down, allowed the practitioner to focus on necessary therapist skills with the family. This stance adds credibility and demonstrates competence in the encounter between family and practitioner.

Learning how to say "I don't know"; "I'm not sure"; and "Let's find out together"; are valuable strengths for the practitioner. Learning how to predict the next family and adolescent behavioural sequence, and dealing with changes after intervention are skills which the practitioner develops with experience.

This practitioner spontaneously used a task assignment directive. Planned interventions such as letter writing, circular questioning, use of team and team message were used. Both spontaneous and planned interventions are valuable as they provide new information to the family in such a way that family members experience a change. Regardless of which type of intervention the practitioner uses, they need to be anticipating family change. One such change could be, the parents struggle to be in charge of their adolescent, the adolescent reacts by becoming more direct and confrontative of

the parent. This new level of family functioning needs to be understood by the therapist so that the family can be assisted to restructure themselves in ways that are more functional for all members.

The development of an hypothesis is a particularily useful skill and intervention. This therapist continues to struggle with forming an hypothesis. More experience is needed to further develop this skill and utilize it as an intervention. This skill involves an ability in the development of relational patterns between family members.

The second focus of the practicum was therapist development. Therapist development involved use of the FTRS for the purpose of obtaining pre and post scores on therapist structuring and relationship behaviours. Use of the FTRS is highly recommended to practitioners, those training in Marriage and Family Therapy, and to clinical supervisors. Use of the FTRS either in combination with individual and group supervision or separate from supervision prepares the practitioner with specific guidelines, and structures further development of therapist behaviours and clinical skills. The opportunity of participating in individual and group supervision can not be understated. This concrete and rigorous process provides opportunities for the therapist to be energized and excited. These elements are necessary and valuable parts of working, learning and growing. For all the theoretical orientation one may have, the application of systems concepts to families involves the art of "doing". Practice, experience and supervision: all are necessary to integrate "knowing". "Doing" and "knowing" become more integrated via the processes of individual and group supervision.

Limitations and anxieties of the therapist were identified by three themes. They are: gender, disappointments - hopes, and relief. A female social work student who participated during group

supervision provided some unexpected benefits. This role model further enriched this experience for the therapist. The therapist recognized and acknowledged disappointments and limitations of the therapist and supervisor. Being more realistic about expectations of therapist and supervisor assisted the therapist. As disappointments and limitations were acknowledged, they were transformed into hopes and goals for the future. Therapist doubts, such as: "Did I do enough?"; "Did I make a difference?", and, "Has this been helpful?", were alleviated. Relief replaced these doubts as an enriched therapist identity was realized. This identity could begin again with new goals and with new tasks. Keeping a log to record therapist observations and experiences during clinical practice is highly recommended.

The third focus of the practicum involved consideration of experiences and observations in the practitioner's place of employment. The anticipation of a beginning collaboration from colleagues involved with intake did not materialize. Given the availability and accessibility of this practitioner during the practicum, expectations of mutual involvement were not fulfilled, as intake did not request the involvement of this practitioner. These disappointments were tempered when recalling commentary and discussion of Murray Bowen. He writes that establishment patterns are similar to the acceptance of new beliefs in a family. And furthermore, there is complementary and rejecting activity on both sides of the issue (Bowen, 1980). Bowen's comments capsulate this practitioner's experience. During this six month period, 'the agency' and those practicing from a family systems perspective became less reactive and better prepared to present systems ideas. Therefore, some movement has been made toward closing the conceptual gap between conventional theory and family system theory in the therapist's place of employment. This was an unexpected 'new place'

for this practitioner.

Finally, the uniqueness of families, and family members must be kept in mind as it is the 'family' who asks for help - not the 'system'. The family and those with traditional theoretical views challenge the family therapy practitioner. Knowing that ideas about family systems threaten basic human notions about individuality, the family practitioner must work on ways to communicate these ideas in ways that are respectful and helpful. The enhancement of opportunities to become pragmatic will serve the family practitioner well, with both the family and in the context of the practitioner's place of employment. Family systems theory does not change anything - it merely provides a different way to think about the human condition (Bowen, 1980).

BIBLIOGRAPHY

Ackerman, N. J. (1980). The family with adolescents. In E. A. Carter & M. McGoldrick (Eds.), The family life cycle (pp. 147-169). New York: Gardner Press.

Bowen, M. (1980). Foreword. In E. A. Carter, & M. McGoldrick, (Eds.), The family life cycle (pp XII - XIX). New York: Gardner Press.

Carl, D. & Jurkovic, G. J. (1983). Agency triangles: problems in agency-family relationships. Family Process, 22, 441-451.

Carter, E. A., & McGoldrick, M. (1980). The family life cycle and family therapy: An overview. In E. A. Carter & M. McGoldrick (Eds.), The family life cycle (pp 3-20). New York: Gardner Press.

Carter, E. A., & McGoldrick, M. (1988). The changing family life cycle. New York: Gardner Press.

Fishman, H. C., (1988). Treating troubled adolescents: A family therapy approach. New York: Basic Books.

Fredman, N. & Sherman, R. (1987). Handbook of measurements for marriage and family therapy. New York: Brunner/Mazel.

Friedman, A. S. (1987). Families of adolescent drug abusers are "rigid": are these families either "disengaged" or "enmeshed", or both? Family Process, 26, 131-148.

Garbarino, J. (1982). Children and families in the social environment. New York: Aldine.

Garbarino, J., & Gilliam, G. (1980). Understanding abusive families. Toronto: Lexington Books.

Gutstein, S. (1987). Family reconciliation as a response to adolescent crises. Family Process, 26, 475-491.

Germain, C. B. & Gitterman, A. (1980). The life model of social work practice. New York: Columbia University Press.

Haley, J. (1980). Leaving Home. New York: McGraw-Hill.

Hareven,T. K. (1982). American families in transition: Historical perspectives on change. In F. Walsh (Ed.), Normal family processes (pp. 446-465). New York: The Guilford Press.

Hartman, A. & Laird, J. (1983). Family-centered social work practice. New York: The Free Press.

Hoffman, L. (1981). Foundations of family therapy. New York: Basic Books.

Hoffman, L. (Speaker). (1985). Beyond power and control: developing a systemic mind, (Cassette Recording, C-90). Banff, Alberta: Western Canadian Conference on Family Practice.

Kelley, P., Kelley, V., & Williams, B. (1989). Treatment of adolescents: A comparison of individual and family therapy. Social Casework: The Journal of Contemporary Social Work, 70, 461-468.

Koman, S. L., & Stechler, G. (1985). Making the jump to systems. In M. Mirkin, & S. Koman, Handbook of adolescents and family therapy, (pp 3-20). New York: Gardner Press.

L'Abate, L., Ganahl, G., & Hanse, J. C. (1986). Methods of family therapy. New Jersey: Prentice Hall.

Madanes, C. (1981). Strategic family therapy. San Francisco: Jossey-Bass.

McCullough, P. G., & Rutenberg, S. K. (1988). Launching children and moving on. In E. A. Carter & M. McGoldrick (Eds.), The changing family life cycle (pp 285-309). New York: Gardner Press.

McGoldrick, M. (1988). Ethnicity and the family life cycle. In E. A. Carter & M. McGoldrick (Eds.), The changing family life cycle, (pp.69-90). New York: Gardner Press.

McGoldrick, M. & Carter, E. A. (1982). The family life cycle. In F. Walsh (Ed.), Normal family processes (pp 167-195). New York: The Guilford Press.

McGoldrick, M. & Gerson, R. (1985). Genograms in family assessment. New York: W.W. Norton.

Melito,R. (1985). Adaptation in family systems: A developmental perspective. Family Process, 24, 89-100.

Minuchin, S. (1974). Families and family therapy. Cambridge: Harvard University Press.

Minuchin, S. (1984). Family kaleidoscope. Cambridge: Harvard University Press.

Minuchin, S. & Fishman, C. H. (1981). Family therapy techniques. Cambridge: Harvard University Press.

Mishne, J. M., (1986). Clinical work with adolescents. New York: The Free Press.

Mohammed, Z. (1983). Family assessment form. Unpublished manuscript.

Molin, R. S. (1986). Covert suicide and families of adolescents. Adolescence, 21, 177-184.

Nelson, T. S., Fleuridas, C. & Rosenthal, D. M. (1986). The evolution of circular questions: Training family therapists. Journal of Marital and Family Therapy,12, 113-127.

Nerin, W. F. (1986). Family reconstruction. New York: W.W. Norton.

Papp, P. (1980). The greek chorus and other techniques of paradoxical therapy. Family Process, 19, 45-57.

Piercy, F., Laird, R., & Mohammed, Z. (1987). Family therapist rating scale. In N. Fredman & R. Sherman (Eds.), Handbook of measurements for marriage and family therapy (pp 170-175). New York: Brunner/Mazel.

Pittman, F. (1987). Turning points. New York: W.W. Norton.

Preto, N. G. (1988). Transformation of the family system in adolescence. In E. A. Carter & M. McGoldrick (Eds.), The changing family life cycle, (pp 255-283). New York: Gardner Press.

Preto, N. G., & Travis, N. (1985). The adolescent phase of the family life cycle. In M. Mirkin & S. Koman (Eds.), Handbook of adolescents and family therapy. New York: Gardner Press.

Quinn, W. H., Newfield, N. A., & Protinsky, H. O. (1985). Rites of passage in families with adolescents. Family Process, 24, 101-111.

Satir, V. (1972). People-Making. Palo Alto: Science and Behavior Books.

Satir, V. (1988). The New People-Making. Palo Alto: Science and Behavior Books.

Satir, V., & Baldwin, M. (1983). Satir step by step. Palo Alto: Science and Behaviour Books.

Selekman, M. (1987). Conquering a chemical monster: A case of adolescent substance abuse. Case Studies, 2, 65-73.

Selekman, M. (1989). Engaging adolescent substance abusers in family therapy. Case Studies, 4, 67-74.

Sherman, R. & Fredman, N. (1986). Handbook of structured techniques in marriage and family therapy. New York: Brunner/Mazel.

Simon, R. M. (1988). Family life cycle issues in the therapy system. In E. A. Carter & M. McGoldrick (Eds.), The changing family life cycle, (pp 107-117). New York: Gardner Press.

Skinner, H. A., Steinhauer, P. D., Santa-Barbara, J. (1983). The family assessment measure. Canadian Journal of Community Mental Health, 2, 91-105.

Stanton, D. M. (1981). An integrated structural/strategic approach to family therapy. Journal of Marital and Family Therapy, Oct, 427-439.

Stanton-Landau, J. & Stanton, D. M. (1985). Treating suicidal adolescents and their families. In M. Pravder, M. Mirkin, and S. L. Koman (Eds.), Handbook of adolescent and family therapy, (pp 309-326). New York: Gardner Press.

Tomm, K. (1988). Interventive interviewing: Part III. Intending to ask lineal, circular, strategic, or reflexive questions? Family Process, 27, 1-15.

Weeks, G. R., and L'Abate, L. (1982). Paradoxical psychotherapy: Theory and practice with individuals, couples, and families. New York: Brunner/Mazel.

White, M. & Epston, D. (1989). Literate means to therapeutic ends. Adelaide: Dulwich Centre Publications.

APPENDIX A: Family Assessment Form
(by Zain Mohammed)

FAMILY NAME_____ (To be completed prior to 4th session)

	Age	Occupation	Ethnicity
Religion			
Father			
Mother			

Children: Age

Others: Relationship

Blended Family Relationships - number of marriages, children by other marriages, etc:

Type of Family: (a) Nuclear (b) Single Parent (c) Extended (e) Adopted (f) Blended

Genogram

1. Presenting Problem -

2. Attempted Solution - Repetitive Nonproductive Behavioral Sequences.

3 Communication and Interaction Styles - (Direct, clear, indirect, confused, vague, double binding, affective, cognitive, positive, supportive, negative, aggressive, etc. . .) invasiveness, receptivity to others.

4. Conflict - Nature of conflict and degree of impairment of group functioning.

5. Negotiation - Efficiency in negotiating problem solutions -

problem solving skills.

6. Affect - Range of expression of feelings, warmth, affectionate, humorous, empathic, overly hostile, depressed, cynical, pessimistic, hopeless.

7. Family Structure - Leadership - chaotic, dominance, shared boundaries - enmeshed, disengaged, clear, spousal relationship, alliances, roles played, implicit and explicit rules, etc.

8. Family Life Stages (Courtship, early marriage, child rearing, parents of teenagers, launching)

9. Pertinent Family-Of-Origin Information (Positive or negative influence from past generation)

10. External Sources of Stress & Support (Outside immediate family: community, work, friends, relatives)

11. Recent Family Crisis or Extended Family Crisis

12. Family Strengths

13. Significant Physical Conditions/Medications

14. Other Information (Previous treatment, test results, etc. . .)

15. Hypotheses Regarding Symptom Maintenance (How might the symptom serve a function)

16. First or Second Order Change

17. Therapeutic Goals

18. Treatment:
(a) Proposed Therapeutic Approach & Interventions (For Reaching Goals)

(b) Anticipated Length of Treatment (Number of Sessions)

(c) Specific Ways System Will Be Improved By Achievement of Treatment Goals

(d) Most Likely Way Therapist Could Fail in Treatment

(e) Are The Clients Aware Of The Treatment Plan? If not, why?

OTHER COMMENTS:

APPENDIX B: Robb Family Letter

Robb Family

Dear Mom and family,

We are writing this letter to you to express how impressed we are with the ways family members show their caring toward one another.

Mom, you have shown your caring toward your children by giving up your own interests. You have sacrificed not attending meetings that are important to you and not going to your friends in order to be a parent to the children.

Jane, you have shown caring towards your mother by continuing to argue for 'less rules'. This has kept you closely involved with one another as you know how important togetherness is for your Mom. As well, this has kept you both together to prove 'trust' between you. Although you would like more quality time with Mom and other family members, you continue to provide opportunities to stay closely involved with the family and especially Mom around your misbehaviours so that Mom continues to be employed in parenting you.

Jason, you have worked the hardest at showing your caring. Your defiant behaviours ensure involvement with your mother as she is kept busy watching over you at home and at school. She monitors you closely to see that you follow through with various responsibilities she has entrusted you with.

Since family members have learned to show their caring towards

one another in these ways, we suggest not changing too quickly as members may not be ready and may find changes too threatening to the way they've learned to stay together.

We suggest that all family members read this letter and discuss it at least three times before we meet for our next scheduled appointment.

Yours truly,

A. Shankowsky, H.B.S.W.,
Counselor

Appendix C: Letter of Permission

June 19, 1992

To Whom It May Concern,

Permission was granted to Anne-Marie Shankowsky for use of "The Family Therapist Rating Scale", and the "Family Assessment Form" for the purposes of her clinical practicum.

Zain Mohammed, Ed.D.

FOOTNOTES

[1]For further information (including availability of the Administration and Interpretation Guide) contact: Dr. Harvey A. Skinner

Addiction Research Foundation
33 Russell Street
Toronto, Ontario
Canada M5S 2S1
telephone 416-595-6297