# THE BRIEF SOLUTION MODEL OF FAMILY THERAPY

BY

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A PRACTICUM REPORT

Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
For the Degree of

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# CHAPTER ONE

## INTRODUCTION

This report is based on my four month practicum/internship at MacNeill Clinic in Saskatoon, Saskatchewan from September to December, 1987. During the internship, I studied family therapy under the supervision of George Enns, Joyce Tremmel and Paul Doerkson.

My application to MacNeill Clinic requested a theoretical grounding in structural family therapy. I hoped to learn how to plan properly for and complete therapy with families. I realized the need to develop a theoretical base from which to use the skills I already possessed in working with different families. The style I had developed prior to attending MacNeill Clinic was to use any "tool" or "trick", rather than using techniques which were based on solid theoretical knowledge. I also requested assistance to understand how to review video tapes, and in turn, to learn how reviewing tapes could be utilized in therapeutic planning. My previous experience with reviewing video tapes was unproductive as I was often unsure what I was looking

for and thus was unclear about their utility. Hence, at MacNeill Clinic, I hoped to gain understanding in both the process of family therapy and the utilization of video tapes to plan family sessions.

The goals established for the practicum prior to beginning training at MacNeill Clinic included the following:

1. to firm up my theoretical and practical knowledge in structural family therapy
2. to receive feedback about my strengths and weaknesses as a family therapist
3. to gain an understanding of how successfully to complete therapy
4. to learn to use measurement tools to determine what changes were attained by families in therapy
5. to gain confidence in my abilities as a therapist.

In my first meeting with George Enns (my primary supervisor), I was informed that MacNeill Clinic was in transition from formerly employing Structural Family Therapy to incorporating de Shazer's Brief Solution Model of therapy. While this came as somewhat of a surprise, I was pleased that I had the opportunity to be exposed to two models of family therapy in one practicum placement. This

was just one of the changes in focus that occurred during the internship.

As stated previously, I hoped to learn how to plan properly for and complete therapy with families. My intention was to learn the steps involved in such planning. I came to realize that to learn to plan therapy required skill in what I now understand as the therapeutic use of self. Therapeutic use of self, as it pertains to this report, is the ability to use your own experiences to understand the problems families are seeking therapy to resolve. Understanding the therapeutic use of self involved an examination of my beliefs regarding conflict resolution, over-coming the need for self-protection by "second guessing" people, and learning to take leadership. The therapeutic use of self has become the structure from which I have incorporated the Brief Solution Model of therapy in my work with families.

The following is a report of the major areas of the learning which took place at MacNeill Clinic. Chapter Two is divided into two sections. Section One examines the major components of the Brief Solution Model as found in the literature, with attention given to aspects of Structural Family Therapy as they pertain to the Brief Solution Model.

Due to my previous training in Structural Family Therapy, there was a continual search to determine how structural skills could be used in the Brief Solution Model. Section Two contains a discussion of readings associated with learning family therapy which were outside the direct realm of the Brief Solution Model. Chapter Three outlines the clinical setting, process of supervision, and the measure of family functioning used as a pre/post assessment tool while at MacNeill Clinic. Chapter Four contains a selective case review of families worked with at MacNeill Clinic. This chapter focuses on interventions and areas of learning associated with those families. Chapter Five contains a personal statement regarding the therapeutic use of self in my practice as well as a summary of the learning which occurred during the practicum placement.

# CHAPTER TWO

## LITERATURE REVIEW:

The literature review I completed during and after my practicum placement, was comprised of writings related to understanding the Brief Solution Model as well as writings which assisted in understanding the therapeutic use of self. For the purposes of this report, these subjects are divided into two sections.

Section One provides an overview of the major elements of the Brief Solution Model citing the work of Steve de Shazer and other authors. Also included are readings which illustrate how Structural Family Therapy skills can be incorporated with the Brief Solution Model.

Section Two addresses literature which assisted my contemplation and eventual understanding of the therapeutic use of self in family therapy.

# SECTION ONE

## BRIEF SOLUTION MODEL OF FAMILY THERAPY

The theoretical model of family therapy in use at MacNeill Clinic during my practicum was the Brief Solution Model, based on the work of Steve de Shazer of the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin (de Shazer, 1988). Structural Family Therapy techniques such as joining, tracking, boundary-making, and other structural interventions are utilized in the Brief Solution Model. A philosophy common to both Structural and Brief therapy is that families already possess, but are not using, the resources they have to solve their problems (Colapinto, 1983; De Shazer, 1988). The Brief Solution Model provides a framework for the therapist to help the family resolve their presenting problem by focusing on the family strengths and solutions they have used in the past to overcome difficulties (De Shazer & Berg, 1988). The Brief Solution Model focuses on problem resolution and not on actively re-organizing the family as occurs in Structural Family Therapy.

Jeffrey Bogdan (1986) compared problem formulation from the

Structural and Brief Therapy viewpoints. He argued that Structural Family Therapy views troubled families as needing to have a problem, at least temporarily, or they would suffer from something even worse. In turn, within the Brief Solution Model problems are viewed as the unintended side effects of well-meant efforts to resolve problems. Problems persist because no one realizes that it is the mishandling that perpetuates the problem. "The result is that the participants keep doing more of the same and the problem continues to crop up" (Bogdan, 1986: 35). Problems are seen in the relationships within the family rather than as residing inside any single family member. By keeping his focus on relationships, where problem patterns are maintained, the therapist remains clear of where both the problem and the solutions lie (Green, 1981; Saponsek, 1980; and Protinsky, 1986). O'Hanlon (1987) summarizes the viewpoint of Brief Solution Therapy in that his emphasis is threefold: what will create the conditions for change, what will resolve the symptom, and what will dissolve the problem.

In the Brief Solution Model, change is seen as a continuous process and therefore clients are asked at the beginning of the first session about changes that have already occurred

in the family between the initial contact and the first interview (de Shazer et al., 1986). The therapist then asks how each family member views the presenting problem. Stephenson (1986) believes that each person will have a separate view of the problem, and based on their assumptions, their attempted solutions make perfect sense to them.

After obtaining a problem statement, the family members are asked for their logic of why the problem exists. Asking clients what they think is wrong or what is causing them difficulty, gives the therapist an indication of the family's world view and how they think about problems (Horn, 1986). To build an intervention that will "fit" (de Shazer,1988: 10) for the family, the therapist needs to understand the family's view of why the problem exists and their previously attempted solutions.

The therapist then asks the family members how they have dealt with or been influenced by the problem. In this way a process description of the behaviour pattern surrounding the problem is obtained. Asking questions about the behavioral sequences related to the presenting problem helps the family look at their attempted solutions differently and thus begin

to examine their belief system about resolving their problem (Stephenson, 1986). The answers given by the family provide the therapist with the family's structure, attempted solutions, stuckness and their approach to problem solving. The easiest way to see the patterns surrounding the problem is to focus on the problem (Watzlawick et al., 1981). In the Brief Solution Model, small difficulties become larger problems through use of "more of the same attempted solutions" which previously worked but are not successful in overcoming the presenting problem (Stephenson, 1986; Watzlawick, 1983; De Shazer, 1988). People come by this problem honestly, in that they grow up with the belief that if at first you don't succeed, try again and again. The result is that the attempts to resolve the problem are tried over and over with no success.

Family members are asked what they are doing different when the problem is not present. The term "exceptions" is used in the Brief Solution Model because clients often misconceive their situation by seeing the problem as always present, when there are usually times where the problem pattern is not present (de Shazer, 1988). The therapist helps the family recognize that there is a different behaviour pattern present when exceptions to the problem exist. It is this

different pattern of family behaviours that can be utilized to promote more non problem patterns in the future. The therapist must help the family recognize the exception as they are frequently not aware of it. Failure to notice what is different when the problem is not present leaves the family unable to see any difference between behaviours that occur when the problem is present or absent (de Shazer, 1988). The therapist's focus on positive behaviours that are present in the exceptions results in a shift toward the family viewing their situation with more hope. It is important to assume that clients already have the resources to solve their problems and if you listen carefully, they will give you the clue or key to the solution (Nunnally, De Shazer, Lipchik & Berg, 1986). By seeing clients as healthy and doing the best they can, sessions are conducted in a positive manner, rather than looking for dysfunctional patterns using the Structural model of therapy. Brief Solution Therapists view families as the experts and encourage them to make whatever changes they see necessary (de Shazer et al., 1986). Another assumption is that families will make necessary changes when they realize what they are doing is not working and when they are able to see alternative ways to deal with the problem.

Solutions develop out of emphasizing the exception patterns without attempting to determine what caused the problem (de Shazer & Berg, 1988). "Any behaviours, perceptions, thoughts and expectations that are outside the constraints of the complaint can be used as building blocks for constructing a solution" (Lipchik & de Shazer, 1986: 89). This focus on exceptions and solutions would appear to be a major shift from Structural Family Therapy in which the therapist focuses on attempting to re-frame the presenting child - based problem into a family problem. The shift is from actively re-organizing the family to constructing solutions which will allow the family to make necessary structural changes themselves. The most powerful feature of the Brief Solution approach is focusing on "what is right rather than what is wrong" to initiate change in families (de Shazer & Lipchik, 1986: 89). Focusing on solutions rather than attempting to re-frame the problem (as in Structural Family Therapy), is a positive approach to working with families because you are looking for strengths which the family already possesses rather than looking at the presenting problem as a symptom. The family is less likely to feel blamed for causing its problem when the focus is on alleviating the presenting problem through the search for exceptions based on strengths which the family already

possesses. Brief Solution Therapy utilizes the principle that people make the best choices possible based on the tools (knowledge and experience) with which they have to work. Any new or different behaviour, other than what occurs when the problem is present, can be used in the construction of a solution (De Shazer et al., 1986).

The "miracle question" (de Shazer, 1988: 6) is then asked of the family members where they imagine their life after the problem is resolved and what would be different. One way of asking the miracle question is, "suppose that one night, while you were asleep, there was a miracle and this problem was solved...How would you know? What would be different? How will your husband know, without your saying a word to him?" (de Shazer, 1988: 5). Answering the question builds the expectation that the problem will be solved and helps move the family toward thinking and behaving in ways to fulfil this expectation. The question indirectly asks about goals and has the family provide concrete behavioral indicators of goal achievement and problem resolution (de Shazer, 1988). It is important to note whether or not the response to the miracle question is based on exceptions explored previously in the session. If the response does not include exceptions involving the presenting problem, then

the complaint is of a broader nature than previously expressed and the search for exceptions should continue (de Shazer, 1988).

Contracting and goal setting can occur by asking how the family will know when the problem is solved; this may, in turn, also point to a possible solution or usable exception. Behavioral goals are used to determine how the clients and therapist will know when the problem is solved, as otherwise therapy theoretically could go on indefinitely. If the clients have difficulty describing how they would know when the problem is solved, the therapist can ask how people outside the family would know when the family had solved the problem (de Shazer, 1988). Brief therapists typically limit the number of sessions at the outset. A clearly defined time frame motivates families to take responsibility for change, to follow the therapist's suggestions and to set realistic rather than utopian goals (Green, 1981). The notion that observable change is expected to occur in therapy is important in the process of contracting and goal setting.

Taking a break before ending a session, to consult with peers, or to sort out information and collect your thoughts if working alone, is advised. Compliments and tasks can be

sorted out during this time (Nunnaly, de Shazer, Lipchik & Berg, 1986). Prior to assigning tasks, "compliments" are given which recognize and draw attention to what the clients' strengths are and what they are already doing that is right for them (Nunnally, de Shazer, Lipchik & Berg, 1986). This is also seen as a way of getting the family into a positive frame of mind which increases the likelihood that the family will complete the assigned tasks.

Once differences between the presenting problem and exception patterns are described by the family and highlighted by the therapist, tasks are given to incorporate those differences (de Shazer, 1988). It is important to understand what tasks the client is most likely to follow. de Shazer (1988) outlines three types of clients and appropriate tasks for each type: visitors, complainants and customers. Visitors are clients who during the interview cannot describe a complaint or where the therapist cannot help the client develop even a minimal expectation of change. Since there is no clear complaint, therapy cannot start and it is a mistake to give tasks; in turn, these clients are given compliments and sent away with no task. Complainants are clients who have an expectation of change, but do not necessarily want to do anything about the

complaint; therefore, tasks should not require them to do anything. The third type of client is the customer who wants to do something about building a solution. It is possible to have visitors, complainants and customers as part of the same family session. Tasks should be given (as therapy progresses), which are consistent for each type of client (de Shazer, 1988). Clients may move within the three categories.

Tasks are assigned in order to get families to act in a way that is different from their typical reaction to the presenting problem. The goal of Brief Solution Therapy is to resolve the immediate conflict situation in as harmless and efficient a way as possible. A phenomenon called the "ripple effect" occurs through creating a small change in the behavioral pattern of the family which creates further changes (De Shazer, 1988). de Shazer (1988) outlines five possible prescriptions or tasks for therapists to choose from, based on the type of client and whether the exceptions available from the interview are consistent with the miracle question. The choices are for the family to: do more of the same, predict outcomes of tasks, look for exceptions, do more of the same while observing reactions, or do something different that has not been attempted thus far. When there

are differences between the presenting problem pattern and behaviour during exceptions to the complaint, the therapist gives tasks that use the difference. The exception pattern is used to promote solutions by asking the family to do more of what they do during the exception pattern (de Shazer, 1988). When the family does not see a difference between the problem and exceptions, but the therapist knows exceptions do exist which are not acknowledged by the family, the task is for the family to predict daily whether the next day will follow the complaint pattern or the exception pattern. The family must then find the logic to account for the type of day they had (de Shazer, 1988).

A general task of getting the family to notice what behaviours are occurring that they would want to have continue is often used after the first session. In this way clients are given the impetus to find their own solutions to problems rather than relying on the therapist for advice. Families often report both good behaviours and some new behaviours that become present between first and second sessions (Nunnally, de Shazer, Lipchik & Berg, 1986).

In subsequent interviews, previously assigned tasks are explored to gain more information. The family is asked

whether its situation is better, worse or the same. It is the information of difference which the therapist can use to promote further change (O'Brian & Bruggen, 1985). The answer to the question written above provides the starting point to explore change in the problem. Clients are asked to describe "whatever steps they have taken toward life without the complaint and the next step is defined and appropriate tasks are assigned until the client is satisfied that a satisfactory solution has been achieved" (de Shazer, 1988: 51). When clients change the task, the therapist should accept that the client knows best what to use for his particular situation. Reports of task performance are then used to modify future tasks (de Shazer, 1988).

# SECTION TWO

## FAMILY THERAPY LITERATURE REVIEW:
## THERAPEUTIC USE OF SELF IN THE BRIEF SOLUTION MODEL

This section contains information from the literature that enabled contemplation surrounding the issue of the therapeutic use of self as it pertains to use in the Brief Solution Model of therapy. The following is a brief discussion of some of the issues which were helpful in the learning process.

Minuchen & Fishman (1981) point out that training in family therapy should require the student therapist to first learn techniques and then forget them. The message is that once the techniques are learned they can they be incorporated into a personal style and used subconsciously. After learning the techniques, the therapist can proceed with learning when and where the techniques can be applied. Once the therapist has learned the techniques used to work with families, such as joining, re-framing, boundary-making, etc., he can then focus his energy on gathering information within the Brief Solution Model framework. The techniques of

working with families are thus taken for granted and the focus for the therapist is to work with the family toward solutions to their presenting problem.

Wardenberg (1988) advocates having a strong theoretical base from which to work with families. Once there is a strong theoretical base, the therapist can use his own unique style. Wardenberg compares doing therapy with playing music. A musician needs a theoretical base from which to create his unique style of music. He states that we are rarely taught to value our spontaneity, but rather that we are taught to think and behave like Minuchen, Satir or our supervisor (Wardenburg, 1988). Wardenburg proposes teaching students that the most valuable part of their therapeutic work is their personal, idiosyncratic responsiveness, most of which they bring with them from their own life experiences. To utilize this knowledge in a sensitive and appropriate manner requires that the therapist have a strong theoretical base, or like the musician, the result will be just a jumble of noise without rhyme or reason. Theory provides the reason behind what happens in using techniques. The Brief Solution Model provides a clear theoretical framework regarding the steps required to work toward solutions with families. The steps within the Brief Solution framework are a clear

problem statement from the family, exploring the family's logic for the continued existence of the problem, behaviour patterns surrounding the problem, exception patterns when the problem is not present and the "miracle question" describing life for the family when the problem no longer exists. Therapists using the Brief Solution Model can express their unique style of working by the way they gather information within this framework.

Stephenson (1986) cites Jeffrey Zieg to point out that therapists should take time to recognize and evaluate what they know and do intuitively in therapy. This process can be assisted in supervision through discussion of the therapist's behaviour that is observed by the supervisor. This process can occur through live-session supervision or through video-tape review.

Another area which supervision can enhance is pointing out unresolved issues the trainee brings with him through his experience. Carter (1986) points out how certain clients trigger emotional discomfort because of the therapist's own unresolved issues. Carter (1986) adds that rather than using clients to work out their issues, therapists should work on their emotional issues outside the helping context. Every

therapist must have either knowledge or personal experience about resolving relationship issues which he can then use in working with families. Thistle (1981) also addresses the need to look at personal issues which then allow the therapist to be more neutral in sessions. He points out discussion of personal issues can occur in supervision based on deadlocks occurring with families being worked with in therapy. Thistle states that students are often more comfortable looking at someone else's problems than their own. Often trainees get bogged down with families in the same places that they experience problems in their own family. Looking at both the therapist's family of origin as well as clinical families helps identify issues that trigger emotional reactions and cause trainees to lose their objectivity and sense of direction in their work. Supervision can also alert trainees to their tendencies, based on their role in their family of origin. Becoming aware of personal issues and beginning to resolve them helps the therapist remain neutral and objective in working with families.

Horn (1988) and Anderson (1988) point out the importance of therapists making use of their experience in doing therapy. Horn (1986) suggests using your own experience to make sense

of what is happening in the family. She indicates that with experience a therapist can more readily see patterns and sequences which can be intervened on more effectively. It becomes easier to lead sessions when we base our actions on our own experience. With experience, therapists can also put more of themselves into sessions without losing control. Anderson (1988) states that while we do not need the same life experiences as our clients, it is helpful to have had and survived some life experiences - the more, the better. Minuchen and Fishman (1981) add that each experience a therapist successfully completes in his own life provides information that can be used in therapy. Through experience we learn about our own strengths and limitations and can then use them in the best interest of clients.

Garfield (1989) points out that therapists should not attempt to be experts who are always in control, but rather just be themselves. By being yourself you let families know you are not imposing your values on their family. Inviting families to know you as a person as well as a therapist provides incentive for families to make themselves available and risk their vulnerability in order to change (Garfield, 1989). Hoffman (1988) says that the things she does have not changed so much as the fact that she's become more personal

and less concealed as a therapist. Having a congruent value system which operates inside and outside of therapy sessions allows the therapist to be himself while utilizing the Brief Solution Model.

Taking leadership in sessions became an important issue during the practicum. Napier (1976) stresses the need to direct the interview and stay on task by asking questions to find out the family's point of view. He points out that it is possible to reassert one's leadership in a gentle way when challenged by the family. Napier also suggests being assertive to push past unproductive talk in sessions. The ability to take leadership is based on a combination of confidence in oneself, knowing what one wants to accomplish and having clear goals in working with families.

Information contained in the literature can be added to personal experience and incorporated within the therapeutic use of self in working with families. Phoebe and Prosky (1980) provide a perspective of the course relationships take. They use a developmental model of intimate relationships in which people choose a mate which is complementary to their own strengths. The inherent struggles (due to differences between the individuals) result in

internal benefit in the form of emotional growth for each person. While relationships contain forces for change and forces for keeping things the same, the authors point out that the only person one can hope to change is oneself. Thus, when something is not working, the individual must try something different. The authors use the example of the "pursuer" becoming the "distancer" to promote change. They point out choices that couples have at crisis points, where changes must be made. As people mature, they seek to become whole and self-sufficient. Phoebe and Prosky (1980) address the points at which couples separate and the tasks they avoid in so doing. They make the statement that there is never a villain and never a hero, each partner is a bit of both. Since we are involved in intimate relationships in our personal lives and every case we see involves relationships, Phoebe and Prosky's articles provide information that is useful in understanding relationship problems that people encounter as a normal course of events.

The search for solutions is the foundation of the Brief Solution Model of family therapy. The therapist can incorporate his knowledge, experience and personal style to work with families using this model. Supervision in the training setting can be helpful to point out and give

direction regarding unresolved issues from the therapist's past. These issues will again be addressed in Chapter Five in the discussion of the struggle for congruence and incorporation of the therapeutic use of self while using the Brief Solution Model.

# CHAPTER THREE

## SETTING, SUPERVISION & MEASUREMENT TOOL

### INTRODUCTION:

The practicum took place at MacNeill Clinic in Saskatoon, Saskatchewan from September to December 1987. On site supervision was provided by George Enns, Joyce Tremmel and Paul Doerkson. George Enns served as chairman of the practicum committee. Barry Trute was a member of the practicum committee and served as the liaison with the Faculty of Social Work at the University of Manitoba. Paul Doerkson participated as the external member of the practicum committee.

### SETTING:

MacNeill Clinic is a government-funded mental health agency whose mandate is to provide assessments and counselling for children and their families. Clients are seen on a voluntary basis and are either self-referred or are referred by community professionals. The staff of MacNeill Clinic is comprised of a psychiatrist, psychologists, a nurse, social

workers and support staff.

The clinic is divided into four specialty areas: Early Childhood Program, Mid Childhood Program, Youth and Family Program, and the Young Offenders Program. The Early Childhood Team provides services to families where the identified patient is between the ages of one and five. The team includes a public health nurse, a speech therapist, a psychologist, a psychiatrist and a social worker. The primary goal of this team is to address the needs of the identified patient and his family through assessment and behaviour therapy. The Mid Childhood Team provides service to families where the identified patient is between the ages of six and twelve. This team also provides multi-disciplinary assessments and behaviour therapy aimed at the identified patient as well as parenting programs to families experiencing difficulty. The Young Offenders Program is run by two psychologists who assess and treat court-mandated adolescents. They also provide group and individual treatment of adolescent sexual offenders using a cognitive/behavioral approach. The Youth and Family Team, of which I was a member, deals with families where the identified patient is between the ages of thirteen and eighteen. The team is comprised of six full-time staff and

two interns, with family therapy being the primary model used to provide service to clients. The Youth and Family Team was divided into two working groups (mini teams) of three staff and one intern. I was on a mini-team with Joyce Tremmel as the leader, plus George Enns and Margo Couldwell.

INTERNSHIP REQUIREMENTS:

Families were seen weekly at the start of therapy, moving to bi-weekly sessions as therapy progressed. At the point of referral, families were asked to complete a Family History Form which outlined key family information as well as the family's perception of the presenting problem's history. These forms were useful in developing an initial hypothesis prior to seeing the family for the first time. MacNeill Clinic is supported through Saskatchewan Health Care for providing service to clients so that cases are registered with Saskatchewan Health Services and given a DSM III diagnosis (Diagnostic and Statistical Manual of Mental Disorders, 1982). The majority of cases worked with during my practicum were registered as either "childhood or adolescent anti-social behaviour" (APA,1982: 156) or "parent-child problem" (APA,1982: 158).

SUPERVISION:

Supervision was provided by George Enns, Joyce Tremmel and Paul Doerkson. I met for supervision with each supervisor for a minimum of two hours per week. Additional supervision was available on request.

Supervision was provided through a combination of live supervision during family interviews, video-tape reviews, case discussion and theoretical discussions. On four occasions supervision was provided by the members of the mini-team of which I was a member. The Youth and Family mini-teams met weekly. Team members alternated receiving live team supervision while completing two initial assessment interviews with newly-referred families. The team members supervised interviews from behind a one way mirror and provided the therapist with "compliments" and "task suggestions" to give to the family at the end of the interview. Post-session feedback was also provided to the therapist by the team. This feedback outlined the therapist's strengths as well as areas of difficulty observed in the session. I received team supervision for four sessions while working with two different families during my practicum.

Fourteen cases were assigned during the practicum with a key supervisor assigned to each case. Supervision was provided by George Enns for four families, Joyce Tremmel for two families and Paul Doerkson for four families. The remaining four families did not wish to pursue therapy, due to the length of time which elapsed between the time of their referral and contact from the therapist or because their problem was solved without therapy.

**MEASUREMENT TOOL: FAMILY ASSESSMENT MEASURE:**

The Family Assessment Measure (FAM III) designed by Skinner, Steinhauer and Santa-Barbara (1984) was the measurement tool used in the practicum. FAM III is a self-report of family members' perceptions based on the "Process Model of Family Functioning" (Steinhauer, Santa-Barbara & Skinner, 1984:78). The process model presupposes that there are certain tasks associated with attaining the goals of successful family functioning. The FAM III scale is the family's perception of their family functioning. It shows the family process rather than showing family structure.

FAM III consists of three separate scales- General, Dyadic and Individual- in which family members rate their

perception of how their family functions. The General Scale measures the overall family functioning, the Dyadic Scale measures perceptions of relationships within the family while the Individual Scale measures how the individual family members rate their own functioning within the family. For the purpose of the practicum I chose to utilize the General Scale exclusively for the purpose of confirming my own assessments of family functioning and also to serve as pre and post treatment changes in family perceptions of their functioning.

FAM III shows members' perceptions of family strengths and weaknesses within seven areas of family functioning, but the therapist is left to ascertain exactly what the problem is within the specific dimension. For instance, a family member whose scale shows a problem in the area of Communication, may be saying there is not enough communication or that communication results in disagreements and unresolved issues.

The FAM III scale is divided into seven subscales, each addressing a separate dimension of family functioning. Each dimension impacts and is impacted on by the other dimensions. The Task Accomplishment subscale addresses the

overall tasks necessary for family functioning. The successful completion of overall tasks depends on the tasks associated with Role Performance, or the roles each family member plays. The Communication subscale addresses how well members are informed of rules and roles within the family. This subscale is impacted on by the Affective Expression subscale which gives members' perceptions of how problematic showing emotions is, while the Affective Involvement subscale shows the amount of emotional closeness in the family and whether it is perceived as a strength or a problem. Along with Affective Involvement is the Control subscale which delineates whether the closeness results in attempts to control the behaviour of each member and if attempts to control pose difficulties. The final subscale is the Values and Norms of the family upon which all other tasks are based. The FAM III scale operates both from Task Accomplishment down to Values and Norms and vice versa. Each subscale impacts on and is impacted on by all other subscale dimensions.

Averaging the results of the seven subscales, addressed above, results in the Overall Rating, which provides an overview of perceived family problems or family strength. FAM III has two additional subscales which provide an

indication of the response style of the respondent. The Social Desirability subscale addresses the issue of the respondent's attempt to answer in a socially appropriate way, either in accordance with the perceived answers of other family members or the perceived expectation of the therapist. The Defensiveness subscale addresses the degree of denial the respondent is experiencing. The more Social Desirability and Defensiveness scores are above 50, the more the therapist should be aware of possible distortions with the rest of the scale.

The General Scale consists of fifty items (statements) which family members answer using a four-point Likert answering system. Answers range from "strongly agree" to "strongly disagree", with moderate responses of "agree" or "disagree" between. Respondents give the response that best represents their response to each statement. The FAM III scale takes less than half an hour to complete and can be used with children as young as twelve years of age.

Presenting FAM III to the family involves justifying its usefulness which is to help the therapist understand the family as well as provide a pre and post therapy measurement of change as perceived by them. No family refused to

complete the FAM III scale at the start of therapy and their comments were all favourable regarding the statements contained within it.

The FAM III scale is useful to confirm the therapist's family assessment. "There is generally agreement between the results of the scale and experienced therapists' assessments" (Steinhauer, 1984: 98). It is also useful to substantiate changes perceived as a result of therapy. My experience with FAM III was that families readily completed the scale at the start of therapy, but few families would complete them when therapy concluded. I can only speculate the reasons for this, as the literature does not address post treatment refusals. It is possible that due to my inexperience in presenting the measurement tool to the families, and the practice at MacNeill Clinic where therapeutic outcomes are not measured, may account for families failing to complete post-treatment measures.

# CHAPTER FOUR

## THE FAMILIES

Three families are examined to highlight aspects of the learning which occurred during my internship at MacNeill Clinic.

The Agassi Family provided experience working with a single parent family where the presenting problem was an acting out adolescent. Case planning and utilization of the Brief Solution Model interview format are highlighted. Included in this discussion are the questions used by the therapist between sessions to plan future sessions. Through guidance provided in supervision and by utilizing the Brief Solution Model I was able to help Mrs. Agassi find alternate solutions to interact with her daughter in a different manner which aided the process of her daughter's returning home to live.

The Jackson family discussion shows the need for the therapist to take leadership and to outline the learning associated with gaining this skill as it occurred in supervision. The goal of learning how to review video tapes

was accomplished through supervision during which Joyce Tremmel and I reviewed tapes sequence by sequence. Supervision using the video review consisted of exploring alternative questions and topics which could have moved the session in a different direction. Reviewing video tapes in supervision proved to be validating as well as informative. The work with the Jackson family also showed the need for clear goals to understand what you are attempting to accomplish with families, as opposed to merely following an interview guideline.

The Reid Family was one of two families who completed the Family Assessment Measure. Through work with this family I was able to utilize the FAM III Scale to validate the changes observed during therapy. The Reid family discussion shows the use of separating subsystems during family interviews to gain information, strengthen boundaries and give complementary tasks.

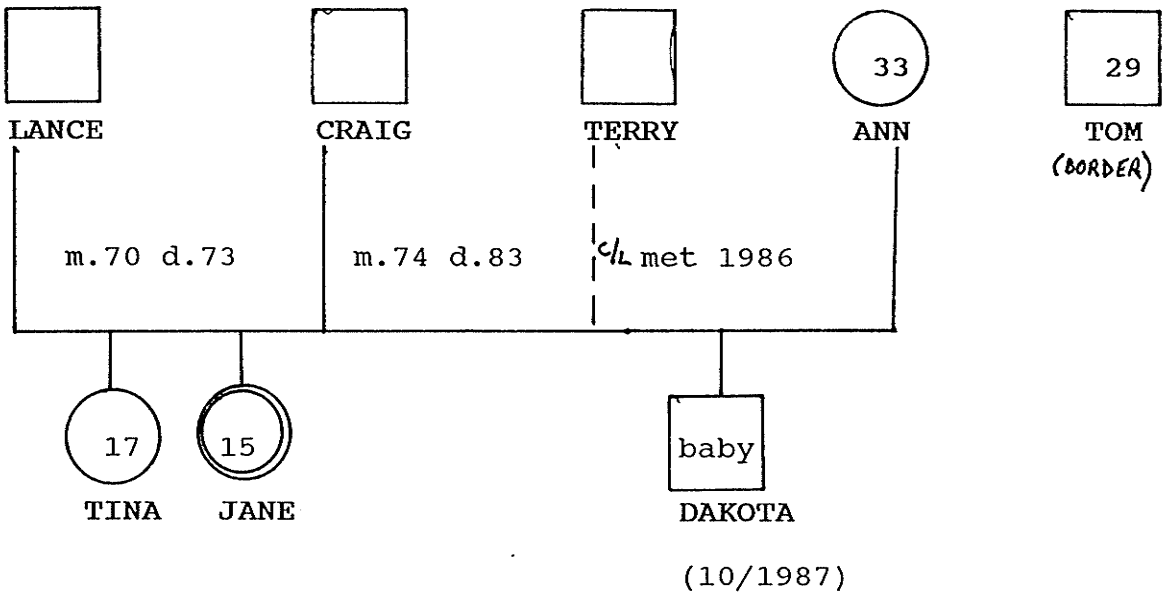
* All family names contained in this report are completely fictitious.

**AGASSI FAMILY:**

Therapy with the Agassi Family provided the opportunity to understand how the Brief Solution Model works. I also gained experience in helping parents struggle with adolescents over issues of control and closeness.

The Agassi Family consisted of a native single-parent mother, Ann, age 33; and two daughters: Tina, age 17 and Jane, age 15. The biological father, Lance, lived in Regina and had minimal contact with the family. Lance and Ann were divorced in 1973, after being married for three years. From 1974 to 1983, Ann was married to Craig. During this marriage, Craig adopted both Tina and Jane and he continued to pay child support for them. A border, Tim, age 29, lived with Ann and her daughters during the time of therapy.

AGASSI FAMILY GENOGRAM *




* Three generation genograms were not utilized in the normal course of therapy at MacNeill Clinic.

SOURCE AND REASON FOR THE REFERRAL:

Ann and Jane were referred by a counsellor at Kilburn Hall, where Jane had been a resident. The counsellor stated that Jane's pre-release visits home had broken down due to unresolved conflicts between Jane and her mother. When the MacNeill Clinic intake worker called Ann to arrange for therapy, Ann stated that the problem was that Jane was trying to act twenty-five instead of fifteen. Ann stated that she tried to enforce rules but Jane continually defied her authority. Ann also stated that she had previously engaged in physical confrontations with her daughter and that, in general, there was a lack of communication between them. Ann believed that the increase in the frequency of arguments was the result of undesirable peer pressure on her daughter.

INITIAL INTERVIEW:

The initial interview framework of the Brief Solution Model was used in the first session with Ann and her daughter Jane. The initial interview framework incorporated four structured questions which helped the therapist obtain the

information which led to a working contract with the family. Sessions were concluded by giving the family compliments about their strengths and tasks which promoted change. The first interview questions were as follows:

1. The Problem:

In addressing the problem, a short description of the problem was sought from each person's point of view.

Ann described the problem as a lack of communication and that she reacted in an angry manner and had previously had hit Jane when Jane would not talk to her about what was going on in Jane's life. Jane stated that she did not talk to her mother because the information would later be used against her.

Jane's perception of the problem was that she felt guilty about taking food and money from her mother, without giving cooperation or respect to her mother.

From the description of the problem and the background information, my hypothesis was that Ann and Jane were struggling over control issues pertaining to distance and

closeness in their relationship. Jane's statement of feeling guilty about her behaviour toward her mother gave the indication that she wished to cooperate so that she would not feel guilty. It was felt that this desire could be utilized in developing solutions to the problem.

2. Members' Understanding of the Problem:

Members' ideas of how they understood the problem were explored. The therapist looked for the logic the family used to continue the patterns in which problems were left unresolved.

Ann stated that Jane was now able to boss her around due to having been lenient with Jane when Jane was younger. Ann stated that when she refused to give in to Jane, Jane had left for periods ranging from a couple of hours, days or weeks. Ann felt that Jane tried to keep everything inside and refused to discuss anything. Ann had previously placed Jane in foster homes and juvenile institutions in attempts to control her behaviour. These placements resulted in a pattern of continual running by Jane. Jane described a pattern where she became angry over not wanting to talk and would leave the room; Ann would then follow her, and finally

Jane would run out of the house. On the occasions where Jane stayed, she and Ann sometimes ended up in physical confrontations.

Ann's responses indicated that she cared very much for her daughter but that her attempts to control Jane's behaviour had not worked. Ann needed to try something different. Jane showed the need for autonomy as well as the lengths she would go to gain this. There was no indication that Jane was running away for pleasure or excitement, but merely to gain space from her mother.

3. Exploring Exceptions to the Problem:

In exploring exceptions, any behaviour which was not part of the problem was highlighted as a possible part of the solution to the problem.

Ann stated that when the problem was not present, she and Jane were able to follow daily schedules and were more comfortable with each other. Jane stated that the exception occurred when there were no philosophical discussions; for example, she and Ann might watch television together and talk about general things, rather than "heavy" subjects. The

"heavy" topics which Jane found to be uncomfortable were Ann's lectures about native culture, sharing, caring, and responsibility. The heavy topics left Jane feeling guilty about her behaviour.

4. Miracle Question:

Family members were asked what they would be doing if a miracle happened and the problem no longer existed.

Ann described Jane and herself sitting down and discussing topics without Jane feeling guilty or angry. Jane stated that her miracle would have her living away from home and visiting Ann on a daily basis, because they would get along better.

Both the answers to exceptions to the problem and the miracle question pointed to the problem of control and the need for autonomy by Jane. Jane's response indicated that she wanted to be close to Ann, but not when she was being controlled. Jane's response to control, either emotional or physical, was to lash out or run away.

5. Compliments and Task:

Compliments of family members' strengths were given to them individually prior to the assignment of tasks.

The compliments included both Ann and Jane's ability to verbalize how they saw their situation and the difficulties they were experiencing. Each person was given compliments about the amount of caring they showed to each other during the session. Ann's concern for her daughter was highlighted, as was Jane's maturity.

The task was for Ann and Jane to take special care to try to keep conversations light and enable them again to be friendly with one another.

The session was concluded by contracting for five sessions of therapy.

**ASSESSMENT:**

Jane proved to be frustrated with the amount of closeness demanded by Ann. Ann expressed concern for Jane's safety on the street; however, the more Ann pursued, the more Jane

ran. Jane also appeared to be struggling to find a balance between the "native culture" her mother described with living in a white society. Unfortunately, Jane was pursuing this balance on the street instead of at home. Indeed, the issue of distance and closeness was central for this family.

**GOALS OF THERAPY:**

1. The first goal was to help Ann pursue her daughter less and therefore eliminate Jane's need to run away.

2. The second goal was to help Ann use guidance rather than futile attempts to control her daughter. Ann was instructed to state her preference for the behaviour she wanted from Jane and allow Jane to make her own decision as to how she would respond.

3. The third goal was to help Ann and Jane open up more comfortable patterns of communicating.

**TREATMENT PLAN AND STRATEGIES:**

The treatment plan was to help Ann use guidance instead of pushing Jane and to use influence instead of power. In this

way Jane could experience some differentiation while still at an age where her mother would be there to help her when she experienced difficulty. In turn, Jane needed to be able to engage in activities with her mother so that Ann could feel more comfortable with Jane's need for some distance.

The strategy was to reframe Ann's activity from overbearing to concern. I helped Ann explore other ways of showing her concern since the use of control was not working for her. The more Ann tried to control, the more Jane ran away.

**PREPARATION THROUGH SUPERVISION WITH GEORGE ENNS:**

To prepare for the duration of therapy I was instructed to look at four areas:

1. What did Ann want? Ann wanted Jane to be at home more, talk to her, listen to her and behave properly.
2. What did I know about the family? It was evident that the more Ann pursued, the more Jane distanced. Ann was attempting to control Jane out of a fear of what would happen to Jane if she continued to run and live on the street.
3. What did I want to accomplish? I wanted to help Ann find a way to stop pursuing her daughter. I wanted to

help Ann guide her daughter rather than try to control her because attempts to control were not working. I wanted to help Jane differentiate safely, but also to help her feel comfortable at home with her mother.

4. Setting the Stage. My task was to find a strategy to help Ann stop her attempts to control her daughter and to have a rationale for the strategy with which Ann would agree. I needed to explore Ann's logic and help her see that what she had done to try to control her daughter, out of caring, had not worked. I planned to help Ann use guidance instead of pushing her daughter and to use her influence rather than power to deal with Jane. Ann needed to try a different way to influence her daughter. I validated Ann's concerns and worries. I built on the reframe of her daughter's needing space, rather than agreeing that Jane was bad. George explained that if the therapist genuinely believes the reframe, he will be more consistent in expanding on it in therapy. This was definitely true in working with Ann Agassi.

**MAIN EVENTS DURING THE DURATION OF THERAPY:**

Ann attended the second session alone as Jane had run away

the previous night with a friend from Kilburn Hall. Ann knew where Jane was living but would not give permission for Jane to live there. Ann saw this move resulting from Jane's having a strong sense of obligation to her friends. Ann felt that Jane would feel guilty about skipping school and her appointment at MacNeill Clinic. Ann stated that seventeen of the previous twenty-one days had gone well.

The compliments and task at the end of the second session were as follows:

> Ann, you are a good teacher and are concerned about your daughter's well-being. You can also appreciate the struggles Jane is facing as an adolescent. I can appreciate how frustrated you are at trying to keep Jane safe from the streets. You would really like Jane to make good decisions and show responsibility, but the more you push and the more power you use, the harder Jane fights you. So what I would like you to do is to use guidance and influence to help Jane learn to make good decisions. Let Jane know what your preferences are and then allow her to decide how to respond. For example, tell her that you would prefer that she did not do X, but that she needs to decide what is best for herself. You stated that Jane feels guilty when she doesn't follow your rules, and she sees herself taking advantage of your generosity by accepting your food and money without giving you anything in return, like not following your rules. Stating your preference and letting Jane decide for herself will force her to feel guilty, but now the pressure will come from inside her rather than from you. Jane will have no one but herself to blame for her mistakes.

Jane stated that she could not follow the task. I told her that was fine and that I saw her coming to MacNeill to look

at alternatives since what was happening was not working for her. I suggested that maybe she could come up with another alternative that would fit for her. Ann stated that it would be too difficult to "back off". Ann then gave an example of how she was already permitting Jane the opportunity to make decisions and take responsibility by allowing her to stay where she was rather than having social workers or the police pick her up. During the session I wondered if Ann was pregnant, as she appeared to be gaining weight. I decided to consult with George Enns prior to approaching the subject of pregnancy with Ann.

George Enns stated in supervision that I had modeled what I wanted Ann to do with her daughter. Instead of trying to force Ann to accept the task, I stated my preference and allowed her to make the decision to follow or not. George suggested that I should continue to ask questions of logic with Ann to help her see how she could act from a position of choice with her daughter. I was instructed to continue to help Ann be firm and clear with Jane about what behaviour Ann preferred. I needed to maintain a neutral stance and not fight with Ann to have her see things my way. Ann needed to be able to handle situations that went wrong in a way that maintained a clear boundary, but without attempting to

control her daughter.

During the previous session I wondered if Ann might be pregnant, as she appeared to be putting on weight. I asked George to help me understand the significance of Ann's being pregnant as it pertained to therapy and the presenting problem. George stated that if Ann was in fact pregnant, it was incongruent with her desire that Jane not go through what Ann had gone through as a child. George questioned the maturity of the decision for Ann to become pregnant at this point in time, while struggling with her teenage daughter.

George pointed out how I had been freer to use myself in the session than I had previously shown. I was now acting out of genuine concern for Ann, rather than attempting to do what I thought was right in the session. Reframing the presenting problem to an issue of helping Ann to gain her daughter's cooperation rather than attempting to control her helped me maintain my focus in the interview.

Ann called to cancel the third session. The following week I called her to learn that Ann had picked Jane up after she had been on the run for two weeks. Ann placed Jane in a foster home, from which Jane ran within an hour and was

still on the run at the time of the call. Ann ended the conversation by saying that since the previous interview she had given birth to a baby that was two months pre-mature.

George viewed the above information as an indicator of the Agassi family providing good practice for me to learn to struggle when therapy does not run smoothly. He stated that he was impressed that Ann was becoming more honest with me, by telling me about the birth of her baby. I was instructed to explore the relationship between the timing of Jane's run with the birth of the baby. I would continue to give tasks toward solutions and let Ann decide whether or not to follow them.

In the third session Ann described how Jane had run away when Ann was transferred by ambulance to another hospital. Ann's understanding of the run was that Jane thought the baby was dying and that it was her fault due to having said bad things to Ann about the baby. Ann stated that Jane was initially excited about having a brother but was also jealous. Jane had pointed out to Ann that it was wrong for her to have a baby and not be in a relationship. Jane had also expressed anger about Ann's hectic schedule which included running a consulting firm for reservations while

also attending law school. Ann stated that Jane had called numerous times while she was on the run and had asked Ann for permission to live with her adoptive father, Craig, an idea which Ann saw as good. Ann saw Jane's wanting to do things differently as a positive step but recognized that Jane lacked the skills in how to go about it.

During supervision following the third session, George reiterated that Ann needed to state her preference clearly - either Jane should live with her or Craig, rather than where she was living. Ann needed to take one position and stay with it, rather than shifting from persuasion to control - by having Jane apprehended and placed in a foster home.

In Session #4 Ann stated that Jane was still on the run but that Ann had been able to locate her. Ann was pleased with her ability to remain calm with Jane and not exercise an attempt to control by having Jane apprehended again. Ann was also questioning herself as to the correctness of not having the social worker apprehend Jane. Ann stated that Jane had called her more often during that run than ever before which left Ann's feeling somewhat better about her decision not to have Jane apprehended. The session ended with Ann's receiving the task of making a list of positive statements

she could make to Jane during phone calls as opposed to detrimental arguments with her daughter.

In supervision George cautioned that Jane's defiance would escalate so that Ann would pursue her. Ann needed to be aware of this and have a plan of action. Jane needed to realize that she did not have to rebel in order to gain control of her life. My task was to explore the ways Ann could be more supportive of Jane.

In Session #5 Ann stated that Jane had moved in with the girl from Kilburn Hall and that Ann expressed her preference that Jane not do this. Jane called regularly while on the run so that Ann knew that Jane was okay. Jane had called to wish Ann a happy birthday and showed up for supper with a card for Ann. Ann was able to see that Jane was showing positive behaviour in spite of where she was living. Ann was able to see that her controlling actions had pushed Jane further away. Ann stated that she was trying to see things from Jane's point of view and that she was able to write a list of positive behaviours she was seeing in Jane. Ann placed the list by the phone so she could refer to it during future conversations with her daughter. Ann stated that sensitive issues still resulted in Jane and herself becoming

angry, but Ann was quicker to back off and the situations did not escalate as in the past. The new task was for Ann to write Jane a letter outlining her concerns about where Jane was living. The session concluded with Ann agreeing to a new contract of five sessions and George Enns would assume therapy with her when my practicum ended.

The following appointment was missed by Ann. After waiting five days, I called to learn that Jane had disappeared after telling her roommate that everyone was coming down on her so that she had to get away. Ann saw this as the roommate's putting pressure on Jane to remain away from home rather than as a result of pressure being placed on Jane by Ann. Jane called two days after leaving to let Ann know she was okay and would return home soon. Ann had friends in Regina keep an eye out for Jane as Ann had received information that Jane was there. While in Saskatoon, Ann had a network to keep an eye on Jane to ensure that she was safe, even though on the run.

In Session #6 Ann stated that Jane had phoned and was angry about Ann's learning that she was prostituting. Jane stated that she had run due to experiencing trouble with her roommate. Ann stated that she had continued to maintain a

cool attitude with Jane rather than getting angry and continued to just state her preference that Jane live at home. George entered the last half of the session to meet Ann in person and complete transfer of the case.

In post-session supervision George pointed out how I had begun to stay with themes longer and was able to carry them throughout the session.

I was told by George Enns that Jane had returned home to stay two weeks after my last session with Ann. He continued to work with Jane and Ann to help them improve their relationship and build on the groundwork that was laid in my work with Ann.

CONCLUSIONS:

The Agassi family provided the opportunity to struggle with learning to maintain my focus and provide leadership in therapy. I was also given the opportunity to see the importance of gaining a clear understanding of the issues presented by the family, prior to continuing with the interview format in completing first sessions.

In spite of numerous issues that could have side-tracked me during the second session, I was able to maintain leadership and focus by helping Ann to see that her previous solutions had pushed her daughter further away rather than helping to bring her closer. The second session issues were that Jane did not show up for the session, Ann was angry and crying, and also that Ann refused to accept the task at the end of the session. I was able, through a clarity and conviction of knowing what Ann needed to accomplish, to stay focused on proceeding toward the goal of helping her not push her daughter away through attempts at control. The lesson from this session was that due to having clarity regarding the information I needed, I could then use any technique at my disposal to gain that information. It was important to learn to ask questions from a neutral position, to ask questions which got at this family's logic for the way things were and to look at what they did rather than why they did it.

Through work with the Agassi family I was able to gain an understanding of how developmental issues are useful in the Brief Solution Model to see what should be happening in the family. It is important for the therapist to understand what a family should be doing developmentally to better help the family focus on necessary changes in problem resolution.

The Solution Model provided a framework to look at change by focusing on solutions. The focus of sessions changed as the family changed but continued toward solutions through helping the family identify whether the problem was better, worse or the same. It was important initially to get a clear picture of how people were dealing with what was going on and where they were becoming stuck.

Work with the Agassi family provided opportunity to understand both the designing of tasks and their assignment. Tasks were set up to get people to do something differently from what had previously not worked. In the case of the Agassi family, tasks were sometimes followed and sometimes challenged. The challenges, that was Ann's refusing to accept tasks, were particularly helpful in providing the experience of moving with the client's energy rather than attempting to push for compliance. Modelling cooperation for the client rather than pushing to control was an important lesson in this process.

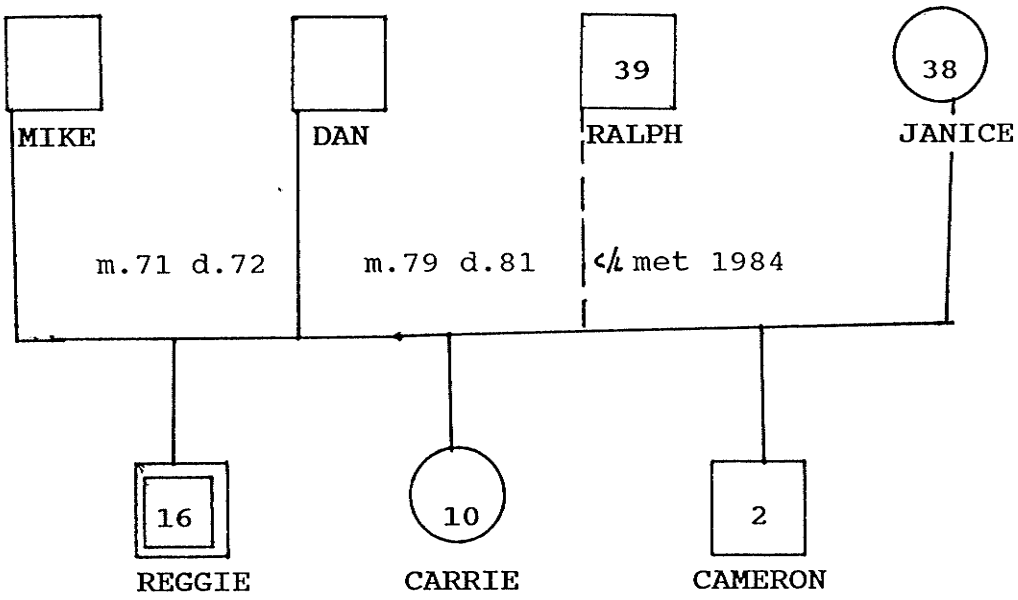
**JACKSON FAMILY:**

This discussion, from work with the Jackson family, includes the need to gain a clear problem definition at the outset of therapy as well as the necessity of showing leadership in sessions. The Jackson family presented an unclear definition of the major family problem which they hoped therapy would resolve. Work with the Jackson family showed the necessity of gaining clarification of the presenting problem prior to continuing through the Brief Solution interview format. Discussion of the strategies acquired through supervision that were used to gain leadership and a clear problem definition with the Jackson family are also included in this discussion.

One of the goals of the practicum was met through video tape review used in supervision with Joyce Tremmel. Through sequence by sequence video tape review I received constructive feedback, validation and encouragement. I saw how tapes could be utilized to see the process of tracking issues which opened the possibility to be aware of alternative questions which could be used in conducting future interviews.

The Jackson Family consisted of a mother, Janice (age 38) who was a housewife, Ralph (age 39) who was Janice's third husband, Reggie (age 16) the identified patient, Carrie (age 10) and Cameron (age 2). Janice was previously married to Mike (Reggie's birth father) for one year, to Dan (Carrie's father) for two years and was in the third year of a common law relationship with Ralph (Cameron's father) when therapy began.

JACKSON FAMILY GENOGRAM:



SOURCE AND REASON FOR THE REFERRAL:

Reggie was referred by his mother (Janice) for counselling due to problems which Janice viewed as his low self esteem and anger. Janice attributed Reggie's difficulties to a lack of contact with his birth father, a lack of communication with her about unresolved issues regarding the reasons for her previous relationship breakups, being raised by a single parent mother and finally the result of her relationship with a recovering alcoholic.

INITIAL INTERVIEW:

Janice and Reggie attended the first interview, along with two year old Cameron. Janice presented herself as a "young" mother overwhelmed by her life circumstances. She appeared much younger than 38. Janice continually expressed her inability to take a stand on issues due to being a victim of her common law husband's "dry drunks". Janice described the dry drunks as drastic mood swings and anger which Ralph had no control over because he was a recovering alcoholic. Reggie appeared older than 16 and behaved like Janice's husband or boyfriend rather than as her son. Cameron spent the entire session bouncing around the room. Although

irritated by his behaviour, Janice did not set limits or attempt to control her young son. Janice had refused to bring Ralph and Carrie to the session as she saw the problem as between herself and Reggie and not involving other family members.

The presenting problem was described by Janice as a need to "change the communication patterns between Reggie and herself to better understand each other and begin to resolve issues". Janice stated that she learned of the unresolved issues between Reggie and herself four months before therapy at which time Reggie came home drunk and had a temper tantrum, during which he brought up a number of issues from the past. Janice stated that she wanted help to "talk straight" with Reggie and resolve issues. Janice also stated that the transition to living with a recovering alcoholic had been especially difficult for Reggie. Reggie's view of the problem was that there was too much tension in the home. Upon hearing this, Janice jumped in to say that problems were forgotten rather than dealt with in the home. Both Janice and Reggie attributed the tension in the family as the result of Ralph's not getting his own way for when he was on a "dry drunk" it was a time that he picked on everyone. Reggie said that Ralph was physically abusive when

he was angry and that Reggie has stepped in to protect Janice from Ralph on occasion. Janice stated she had come to Reggie's aid as well.

I was confused at what appeared to be a complete turnaround from the presenting problem. The referral information and Janice's definition of the problem at the start of the first session indicated that the problem for which she was seeking help concerned her son and possibly unresolved issues in their relationship. When Reggie described the problem as involving Ralph and the tension in the home, I became confused as to what the real problem was, but I was hesitant to question this for fear that I was prematurely moving into a marital problem, when the request was for help with Janice's son's behaviour.

In spite of not having a clear problem definition, I assigned a task at the end of the session. The task was for Janice and Reggie to notice what was happening when things were going well in the family in the following two weeks. I had proceeded with the Brief Solution interview format without attaining a clear problem definition. My rationale for proceeding to look at problem patterns, exceptions to the problem, and asking the miracle question before gaining

a problem definition was that the first interview had been running for what seemed like a long period of time without much progress toward seeing a clear problem. I erroneously hoped that by proceeding with the interview format I could get a better picture of the problem for which the family was seeking help. In effect, I became caught up with following the interview format rather than seeing the need to fully understand the information needed in each portion of the interview and how the information of each part builds on the previous work.

**PREPARATION THROUGH SUPERVISION WITH JOYCE TREMMEL AND MAIN EVENTS OF THERAPY:**

Supervision with Joyce Tremmel, using video tape review, focused on my attempts to reframe and clarify Janice and Reggie's presenting problem and the possible alternatives. Instead of saying "you want to have more communication", it would have been preferential to say "it sounds like you would like to get along better with your son, is that true?" I also could have said to Reggie "you would also like to get along better with your step-father, is that true?" Another opening would have been to track Janice's logic and world view by asking more questions instead of attempting to

clarify what they were saying. I became caught in the content of the description of the "monster" that Janice and Reggie lived with. They had described Ralph as a six foot five inch, recovering alcoholic, whose behaviour was excused by both Janice and Reggie since the behaviour was based on the "dry drunks" which were outside Ralph's control. In attempting to gain a concrete problem definition between Janice and Reggie, I had missed the real problem they were attempting to solve. The real problem was that due to tension in the home issues are left unresolved.

My hypothesis prior to the first session was that Reggie acted out to supply a release valve for Janice to focus on rather than dealing with the real source of the tension, which was her relationship with Ralph. Supervision focused on learning to ask better questions which would broaden the definition of the problem and challenge clients' world views. World views are the beliefs the family has for the way things are. Following Janice and Reggie in their stories reinforced their world view that Ralph was a monster and nothing could be done to change that. I needed to pursue the sense they made of what was happening in their home and thus help them challenge their logic for the way things were in the family in that issues were seldom resolved. In order to

track my hypothesis, I needed to find out how frustrations became a problem for Janice and to explore her logic as to why the frustrations continued to fester rather than get resolved.

The plan for the second session was to track the problem from the start of the interview and to explore their logic rather than following the stories of Janice and Reggie. The theme I would base my questioning on was that Janice needed to take a stand with Reggie as well as with Ralph to begin to resolve issues. Joyce suggested I broaden any problem given by Janice or Reggie to find out how other people in the family saw the situation.

Janice began session two by stating that it had been a difficult week because Ralph's business couldn't pay the bills. She stated that she was using borrowed money to pay family bills. Janice stated that she was worried about being stuck with the bills if the relationship ended, just as she had been left with an $800 bill from her second husband. Janice stated that Ralph had been juggling the finances but was leaving her in the dark about what was really going on. Janice stated that the first week after the last session had gone well because no one "bitched", but that during the

second week Janice and Reggie had been involved in a terrible argument which resulted in her throwing him out. Reggie responded by kicking in the door. Janice stated that Ralph's moods set everyone off, with the grouching going down the line from Ralph to Janice or Reggie, Janice to Reggie, Reggie to Carrie, Carrie to Cameron, and Cameron to the cat. Janice stated that the tension was worse than in her previous relationships because Ralph tried to control her financially.

I attempted to bring the topic back to the presenting problem which was Janice's perception that past marital breakups and the lack of involvement with his natural father resulted in low self esteem and anger for Reggie. Reggie stated that he was disappointed but that neither area was a big issue for him. Reggie appeared unconcerned about Janice's concerns, as evidenced by both his unemotional tone of voice and his relaxed body language. Reggie stated that he had been able to get along with each man Janice had been with. Reggie stated that he was content with his situation, but did not like the tension in the home. Attempts to focus on possible solutions resulted in Janice's stating that she could refuse to get a loan to bail Ralph out of the financial mess or she could get a part time job even though

she did not want to. The task at the end of the session was for Janice and Reggie to think about the issues they really wanted to discuss, since their presenting concerns were apparently no longer an issue.

As was the practice at MacNeill Clinic after the second session of family work a structural assessment, treatment goals and treatment strategies was written. This process was particularly helpful in working with the Jackson family due to the need to become focused on what was needed for them to complete therapy.

**STRUCTURAL FAMILY ASSESSMENT:**

The Jackson family were experiencing contaminated developmental issues in which Janice and Ralph were at the stage of becoming a couple while being forced to adjust to the needs of a family with an adolescent getting ready to leave home. The Jackson family was a newly blended family who had not made any long term commitments. The parent-child boundaries were diffuse with Reggie actively functioning in the parental and spousal subsystems. Janice and Reggie presented as peers rather than as mother and son. The spousal boundary was rigid with Ralph's being disengaged

from Janice and replaced by Reggie. Reggie was used to deflect conflict between Ralph and Janice. It was possible that Ralph was jealous of the relationship between Janice and Reggie as evidenced by Ralph's moodiness as well as his refusal to share financial information with Janice. Reggie was triangulated into the marital relationship so that issues were not resolved between Janice and Ralph. The function the tension in the family served was to keep Janice and Ralph from becoming close or making a commitment to each other. The dysfunctional pattern in the family was that no one made a stand or declared their position and therefore no issues were resolved. Janice attributed her inability to make a stand with Ralph to her victimization by Ralph's moods. The result was that family members were left frustrated by their inability to resolve issues.

**TREATMENT GOALS:**

1. De-triangulate Reggie and allow him to differentiate.
2. Clarify family boundaries.
3. Help Janice make a stand regarding her position in the marital relationship.
4. Help the family work through issues to the point of

resolution.

**TREATMENT STRATEGIES:**

1. Get the family to describe exceptions to the presenting problem, where issues are resolved. Attempts would be made to connect the theme of tension in the home to that of unresolved issues.
2. Highlight behavioral indicators and validate Janice's strengths in order to challenge the world view that she is a helpless victim of Ralph's moods.
3. Reframe Ralph as a sensitive and insecure man who needs clear statements and support. This would challenge Janice's description of the 6'5", moody, monster of whom people are afraid. Question Janice's ideas about her relationship with Ralph and the need to continue the pattern of avoiding issues.
4. Challenge Janice's ideas that her previous marital difficulties resulted in Reggie's behaviour, thus removing the guilt she feels and enabling Janice to hold Reggie responsible for inappropriate behaviour.
5. Validate and highlight situations where Janice is able to take a stand with her sister, with her friends, and with Reggie. In this way Janice can build the

strength to be also clear and take a stand with Ralph so that the pattern of leaving issues unresolved will change.

6. Encourage Janice to negotiate issues with Reggie, because trying to control and force his behaviour will be difficult to be successful with. Encourage Janice to hold Reggie accountable for his actions, thus clarifying the parent-child boundary.

7. Challenge Janice and Reggie to practice resolving less sensitive issues which could include curfews and swimming lessons, so that Reggie could help his mother gain the experience of working issues through, so that she may be able to work issues through with Ralph. Reggie would also gain valuable experience in working through issues rather than continuing the family pattern of avoidance, which will better prepare him for adulthood.

8. Encourage Janice to share information with Ralph about non-sensitive issues as a means to break the established communication pattern which was based on her expectations of Ralph's either becoming angry or refusing to talk about any issue. Janice's expectations reinforced the pattern of keeping Ralph and her distant and from resolving issues. The spousal boundary would

also be strengthened through appropriate communication between Janice and Ralph rather than between Janice and Reggie.

9. Encourage Janice to deal directly with Ralph so that Reggie would no longer be caught in picking sides. In this way Reggie would become de-triangulated.

10. Use the task of getting Janice and Reggie to make note of what people were doing when things went well in the family. Any information from this could be used to help explore their logic for changing other areas such as unresolved issues.

11. Explore the logic and understanding Janice had for not taking a stand with either Reggie or Ralph.

12. Focus on solutions rather than continuing Janice's pattern of avoidance and attributing every issue to the past which left her no options for change.

**SUPERVISION WITH JOYCE TREMMEL & MAIN EVENTS OF THERAPY (continued):**

In supervision with Joyce Tremmel, I was instructed to help Janice make sense of her situation through challenging, directing or letting her talk. Any of the above-mentioned options could be utilized with the purpose of showing

therapeutic leadership in the session. Challenging Janice's beliefs occurred through tracking issues more deeply rather than moving on too quickly. I challenged Janice's belief that she was a victim of Ralph's moods by asking her "why is that?" How did Janice and Reggie make sense of being victims? I also injected new possibilities through the use of "yes...but..." statements which provided new possibilities to be thought about. With the problems that families like the Jackson family bring to therapy, the challenge is to find out what the relationship is between those problems as the problems are usually related. The example of this that was most blatant was the presenting problem concerning unresolved issues between Janice and Reggie which was the same as the unresolved issues between Janice and Ralph. When given content by the family, I began to ask myself if the content made sense as it related to the presenting problem. If it did not make sense I continued to ask questions until it did make sense. Asking questions to gain clarity shows therapeutic leadership and helps families look at the logic they use to keep problems from being resolved.

Through reviewing video tapes of the first two sessions in supervision, I was able to see that the problem was not the

stress and tension in the family, but rather how the family dealt with stress and tension. Joyce stated that I gave nice clarification to the family, but I could have tracked issues further so that the questions would have more impact to help them question their logic. For the third session I was instructed again to ask Janice to bring Ralph to the following session to begin work on resolving issues. The rationale for Janice to invite Ralph was that everyone in the family was hurting, even Ralph, because issues were never resolved. Ralph was a victim, just as Reggie and Janice were victims, but victims of tension resulting from unresolved issues, and not victims of Ralph's moods.

In the third session, Janice stated that she and Reggie had been unable to talk through any issues, but did say that she had begun to resolve a long standing situation with her sister by engaging in dialogue through letter writing as they could not resolve issues when together. This exception to the previous pattern of leaving issues unresolved was used to promote further resolution of issues. After hearing the rationale, Janice agreed to invite Ralph to the following session to help work on the problem of issues never getting resolved.

Supervision following the third session focused on my validation of Janice for being able to see the pattern which prohibited issues from being resolved and her change in beginning to resolve issues with her sister through letter writing. I continued to focus on exceptions which showed areas where the family was already doing well. I continued to help Janice look for available ways to get the message to Ralph that issues could be resolved between them.

In session four both Janice and Reggie appeared different in that the giggling and laughing of previous sessions had ceased. Both stated that things were not bad at home, but continued to attribute this to a lack of Ralph's "dry drunks" rather than any change in behaviour patterns. Janice stated that she invited Ralph to attend therapy, but that he declined, a refusal which Janice attributed to his not being ready to come yet. Ralph had previously seen other counsellors with Janice but the sessions had not been helpful from his point of view. Janice stated that she had made another stand with Reggie since the previous session. Reggie had been caught skipping school and Janice made him spend the school hours out of the house, an action which resulted in Reggie's getting himself back into school. Janice stated that she initially got angry, but quickly made

her stand with Reggie, where previously she would have backed off and stayed angry for days instead of taking a stand. Janice stated that she was closer to being able to bring up issues with Ralph. Previously issues only came up during arguments or when one of them was already in a bad mood with no hope for resolution. The task given at the end of the session was for Janice to continue to practice working through issues with Reggie. The goal was to solidify the parent-child boundary and also give Janice the additional practice in making a stand rather than getting angry and backing off from issues.

Janice called to postpone the fifth session until after Christmas, as things were too hectic to come in. She stated that things had been good the previous two weeks, especially with Reggie. I explained that Joyce Tremmel would take over the case after Christmas, and asked Janice if she and Reggie would fill out the FAM III scale, to which she agreed. The second FAM III was never filled out.

The Jackson family was transferred to Joyce Tremmel at the end of my practicum placement. The problem of resolving issues had been partially dealt with, but the work with Ralph and Janice together was still necessary.

**LEARNING RESULTING FROM WORK WITH THE JACKSON FAMILY:**

My work with the Jackson family showed the need to take leadership in therapy. By following the family and the content of their stories, the initial problem definition took a number of sessions to clarify. I initially became locked into seeing Ralph as the monster Janice and Reggie described, an interpretation which blocked any possibility of questioning their logic of the situation. I needed to watch for subtleties in what was said, and not try to help until there was clarity about what the problem was. Failure to see the underlying theme of unresolved issues that the family presented resulted in futile attempts to work on unclear problems. Once I took leadership through asking questions rather than listening to their stories of misery I became much more focused in the interviews.

Work with the Jackson family showed that when a therapist does not have a clear picture of what the patterns are in the family and there is no clear problem definition, he should continue to track each issue the family presents until he and the family can become clear about what problem will be resolved in therapy. This process can be aided by asking when, where, why, how and what if questions based on

the hypothesis of what the therapist thinks may be occurring in the family which is causing their difficulty. By thinking in terms of a key theme for the family, the therapist is more likely to stay focused on the information he requires, as opposed to focusing directly on the content of the presenting problem and aimlessly following an interview format. With the Jackson family, the theme was their inability to resolve issues. Upon finding this theme, questions became more deliberate and productive allowing therapy to flow more easily.

In reviewing video tapes during supervision, Joyce provided validation and encouragement. I was able to see where I let the topic or focus slide and also where I was asking better questions or could ask different questions to gain more information. Through reviewing video tapes with my supervisor, I was also able to look at what I would try to do differently in future sessions.

In working with the Jackson family I was able to see the importance of showing leadership in sessions. I also experienced the frustration which occurs from following the interview format rather than focusing on gaining a clear problem definition from which to proceed. I was also left

with a clearer understanding of the utility of video tape review.

**REID FAMILY:**

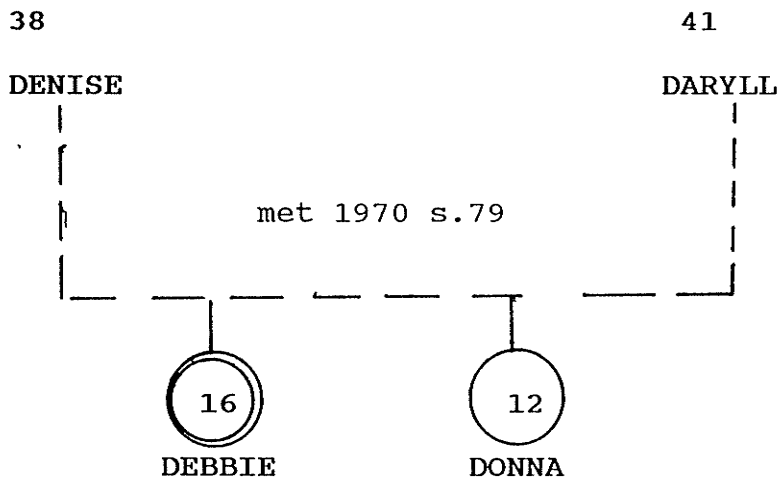
The Reid family was one of two families who completed pre and post treatment Family Assessment Measures (FAM III scale). FAM III provided an opportunity to validate the changes shown by the family in the course of therapy. The FAM III results were particularly important to this therapist since the Reid Family was a multi-problem family where dysfunction had been long-standing which meant even small changes, as the family perceived, should not be discounted. The Reid family was not cured or fixed during the nine sessions of therapy, but they did make progress toward attaining an amicable living arrangement through resolution of their presenting problem.

Advantages through the use of separate interviews with the child subsystem and the parent subsystem are discussed as they were implemented with the Reid family. The ability to "validate change" and to "move with the clients' energy" is also highlighted as it pertains to therapy with the Reid family.

The Reid family consisted of mother: Denise, age 38, who was on welfare; and two daughters- Debbie, age 16 in a modified

grade 10 program and Donna, age 12 in grade 7. There was a common law, biological father, Daryll (age 41) who most often lived away from the family to satisfy the conditions of welfare. Daryll was described by the Reid family as having a serious drinking problem and that he became violent when he drank.

REID FAMILY GENOGRAM



**SOURCE AND REASON FOR REFERRAL:**

Denise was advised to call MacNeill CLinic, by the Crisis Unit of the Department of Social Services, whom she spoke with as a result of Debbie's running away from home and threatening suicide. Denise told the MacNeill Clinic intake worker that her daughters would not listen to her, would not cooperate and that they fought constantly with each other. Denise added that there has been a lack of discipline in the home and that the problems had been present for five years, but are now worse. Denise stated that she no longer knew what to do about the problem and the stress was too much for her to cope with.

**SUPERVISION WITH GEORGE ENNS & MAIN EVENTS OF THERAPY:**

The first session with Denise and her two daughters was conducted with the team (George, Joyce and Margo) behind the one way mirror. Denise described Debbie and Donna's fighting and lack of respect toward her as a major problem, which was consistent with the referral information given by Denise. During the session, Daryll's drinking and violent outbursts was described as the most important problem in the home. Denise and Daryll had separated in 1979, with Daryll's

visiting the home three or four times per week since that time. Denise stated that the girls should have access to their father and thus she promoted the visits. After a break in the session, I was provided with a number of compliments to give Denise and her daughters, plus the task of having each person make note of what they see when things are going well at home. A five session contract was set up to work on Denise's difficulties with her daughters as well as help with the difficulties the family faced with Daryll's behaviour. At the end of the session, Denise and her daughters agreed to complete the FAM III scale, as it would help assess how much change occurs during therapy.

While the presenting problem was the behaviour of the girls, it was hypothesized that their behaviour served to protect Denise from missing Daryll while he was living out of the home. The behaviour of the girls was the excuse Daryll used to continue living away from the home. Denise used the behaviour of the girls to focus her energy on, rather than spending her energy missing Daryll. Debbie and Donna showed a great deal of care and respect for their mother and it was felt that using this energy could resolve the presenting problem in such a way that the problem of Daryll's drinking and violence could subsequently be dealt with.

In supervision, George Enns instructed me to find out where Daryll fit in the family picture and find the pattern of what he did when Debbie ran away from home. I was to begin by exploring the family's thinking and their understanding of the problem as well as what Denise had tried with her daughters to overcome the problem. The threat of suicide is a metaphor for a hopeless situation; therefore, I had to find the reaction of the family when Debbie made these threats. Was there a consistent family pattern, in which Denise nagged Daryll as she did with the girls, instead of stating what she wanted to have happen? The task was to get Denise to do something different, preferably something unpredictable. To search for solutions I was to find out if Denise wanted Daryll or did she want to be rid of him, what had she done to have him behave differently and what would help Daryll to deal with his drinking problem? I was to track in a positive direction, toward how things would be different in the family, by "opening a window for Denise to see out of". Denise wanted Daryll, but needed to take a stand with him, so that I could use this motivation to help her get what she wanted. Denise had a world view of being a victim, but she needed to take leadership with her daughters and with Daryll. I was to stay neutral, see Denise's way of understanding and help her find a different stance by

validating her and helping her look for alternatives. George instructed me to be careful not to invalidate Denise as she could be fragile from other people's invalidating her. Due to Denise's engaging people from a one-down position, it was more important to validate her and not to criticize or invalidate her. I needed to find out what prevented her from changing when people told her what to do with her daughters and with Daryll.

In planning therapy for the Reid family it was important to understand what they wanted to have happen. Denise wanted Daryll back in the family even if he didn't quit drinking. She also wanted her girls to behave. The second area of planning was to evaluate the information I had gathered concerning the family. Denise was motivated to get Daryll back. Denise wanted to be closer, while Daryll wanted more distance. Denise tried to get Daryll closer by signalling that she needed him to help control the girls, but Daryll would withdraw and blame the girls rather than helping. Denise engaged people from a position of helplessness. Finally, I examined what I wanted to accomplish in working with the family. The patterns that were defeating the family were that Denise could not take a firm stand with her girls nor with Daryll and that she engaged people from a helpless

position. It was important to fit my logic with her logic. Denise needed to believe that taking a stand would be beneficial for herself and for her daughters. Denise needed to take a stand on one thing - anything. Denise was told that by taking a stand with her girls, she would gain Daryll's respect as he could then see her as a strong person on whom he could rely.

A decision was made to work with Denise and her daughters, excluding Daryll from therapy, for two reasons. The first reason was that the problem presented by Denise concerned only her daughters and the second reason was that overcoming Daryll's drinking problem required Denise to take a firm stand with him. Denise needed to build the strength to make a stand with Daryll and it was believed that this could occur after she saw that she could control her girls without outside assistance from Daryll or anyone else.

In the second interview I was instructed by the team to use separate interviews with Denise and her daughters, to gain individual viewpoints and assign complementary tasks. Debbie and Donna were validated for their concerns about Daryll and their mother and were asked about differences in Daryll's behaviour and what difference it would make for them if he

stayed with their family and what difference it would make if he quit drinking. The post-break message to the girls was to acknowledge their concern for their mother and how upset they were. They were asked to show the utmost loyalty to their mother, especially when Daryll was present, in order to show what a good mother they had. Otherwise, Daryll could say Denise was a bad mother who could not control her daughters. They were asked to take this a step further and offer to help their mother even when they weren't asked. In this way they would show Daryll what was really going on and they could show him up. Both Debbie and Donna agreed to cooperate.

To set the stage for the intervention with Denise I was to get a clear picture of what motivated her, what her logic was for Daryll's not living in the home and what Denise thought would help him want to be around more. Denise was told that she needed Daryll's cooperation in order to handle the girls. She was instructed to ask Daryll to back off while she gained control of her daughters. She was asked to let the girls know she appreciated it when they did their chores and cooperated. It was important to appreciate Denise's dilemma and to use her logic for why the problem was not cleared up.

In the interview with Denise, I asked for her understanding of the problem with Daryll. Denise was given the message that she should not be used by Daryll as a part-time wife any more and that Daryll needed to decide whether he would live with her or not. Denise was also instructed to tell Daryll that she was the mother in the house and that she did not want him to tell the girls what to do unless he was living in the house. Denise was told that a possible reason for Daryll's drinking was that he did not have the confidence to take charge of his life. This frustration caused Daryll to become violent. By taking a stand with him, Daryll could see Denise as someone he could lean on while getting himself together and dealing with his drinking problem and violent behaviour.

Separate interviews were used to gain the girls' point of view and to assign a task which would complement the task given to their mother. Separate interviews were used for Denise and her daughters to build on positive information and re-frame negative information to get Denise and Debbie to get along better. I would prepare the girls for the difficult time their mother would have with sadness and loneliness while waiting for the situation to change with Daryll. Denise was instructed to win Debbie over by leaving

notes that she missed her daughter when Debbie came in late and by trying to say something nice to her daughter when Denise felt like getting angry with her. Denise was also coached about what to expect from Daryll. The girls would also be coached to expect Denise to be critical of them due to her loneliness and hurt; in turn, they should do some chores and to say something nice to their mother when they were angry with her. They were also instructed that Daryll may try other "tricks" in order to get them to act up so that he could point the finger at them and not take ownership for the drinking being his problem. The reason for the girls' behaviour was linked to protecting Denise from Daryll and therefore it was easier to re-frame his behaviour to the girls as a "bad guy" rather than as a "sad guy" or as a person needing help. There was no "bad guy" in reality, just four people playing their respective roles in a difficult situation.

In Session #3, Denise expressed frustration as Daryll had ceased visiting. Daryll informed Denise that he would only return when Denise got the girls straightened out. Daryll's readiness to cooperate was unnerving to Denise as Daryll left before Denise could tell him to leave. Daryll's leaving resulted in Denise's becoming afraid that she would lose him

forever. Denise needed to be validated for her progress toward taking a stand with Daryll as well as gaining the cooperation of her daughters. Due to fear, anger and frustration that Denise expressed at the start of the session, I was unable to maintain my intended focus of validating change. The girls had cooperated much more, but due to my focus on what I perceived to be Denise's losing ground in becoming stronger, this went without being validated in the session.

In supervision with George Enns, I was instructed to begin Session #4 by backtracking to the information gained in Session #3 to focus on tracking and validating the changes the Reid family was making. George had instructed me to set up another interview as soon as possible to validate the changes which were not validated in the previous session; otherwise, the crisis would escalate with the family. The goal with the Reid girls was to help them continue to cooperate with their mother. The goal with Denise was to help her take a stand with the girls and with Daryll. Denise was given the task of asking Daryll to let her deal with her daughters so that he could spend time building up his relationship with the girls, instead of trying to discipline them. In Session #5 the changes were further validated and

cemented through validation of the girls and Denise. I re-contracted for an additional four sessions as the situation was still extremely unstable in spite of the improved behaviour by Debbie and Donna. George pointed out Daryll's anger was based on his insecurity as he was losing his position in the family and was forced to deal with the real cause of his difficulties - his drinking. Denise would have to let Daryll know he could lean on her, but she had to take a stand on his anger. Denise would be instructed to do more activities with Daryll while making a stand with him, indicating that she would not tolerate his anger.

Supervision focused on my job, which was to help Denise stay strong, even if Daryll opted out of the family. The girls were instructed to continue to cooperate while their mother became stable and Denise was instructed to remain firm in her stand with Daryll. Denise needed to be told that the girls would only cooperate for so long, if she didn't take advantage and make a stand with Daryll. George spent time explaining how I had to be aware of the possible changes that may occur. I would watch and predict to Denise that there could be trouble ahead in which Daryll may drink more or be around less and the girls may act out. I would continue to emphasize to the girls that their cooperation

was more important now than ever. The goal was shifting toward Denise and Daryll improving their relationship, as the girls were now cooperating most of the time. I needed to focus more on Denise and what was going well rather than focusing on individual issues. I would question Denise's logic in that she refused to take credit for any changes that had occurred. Rather than arguing about Denise's role in the changes it was important not to dig in with this type of family, but rather to focus on what's going well and continue to question her beliefs. Parents will often highlight what kids are not doing, rather than what they are doing well.

Session #6 focused on the changes Denise was making as well as the cooperation her daughters were showing. Denise expressed concern about Debbie's sexual activity with her boyfriend. We explored various options Denise could use to deal with this issue in a non-controlling and non-threatening way. Denise and Debbie had made some major moves toward cooperation and the use of control could have undermined these changes.

In session #6 I was able to validate the changes and also to deal with the new complaint involving Debbie's sexual

activity without losing my overall focus, which was the confidence Denise was building as well as the cooperation the girls were showing. In supervision I was told to be conscious of the developing pattern of Denise's taking out her anger on Debbie when she was actually frustrated with Daryll. Denise needed to focus her action toward the appropriate person, Daryll, rather than backing off or attacking Debbie.

In Session #7 Denise and her daughters showed excitement over the changes that continued. Denise had moved to being able to see Daryll's temper was clearly his own problem and that Debbie had no part in it. This was a dramatic shift for Denise who had previously sided with Daryll in blaming all family problems on Debbie's misbehaviour. When questioned about how she would deal with Daryll's drinking and violent behaviour, Denise stated that rather than fighting with him, her plan would be to take the girls and leave. Denise stated that even though Daryll was still drinking, he had begun to change. The change included asking Denise to buy a house with him as well as being more polite to her. Denise felt it was better to wait until she was sure he would continue to stay with her. Denise smiled as she spoke of the change that was beginning with Daryll, giving the sense that she enjoyed

her new feeling of some control in their relationship. When asked how she had dealt with her concern about Debbie's sexual activity, Denise stated that she had been able to tell Debbie her preference about Debbie's sexual behaviour and the need for birth control, rather than getting angry as had previously occurred.

Session #8 focused entirely on Daryll, as the girls continued to cooperate. Daryll had made attempts to blame his behaviour on the girls, but Denise pointed out the errors in his thinking. Denise stated that she continued to help Daryll improve his relationship with the girls, but she was afraid he would follow through on his threats to leave her.

Session #9 was held to transfer the family to George. He would work with Denise to help her take a stand with Daryll. Denise and her daughters agreed that the problem of the girls was successfully completed. Denise felt they had moved 40 out of 50 steps; Debbie saw the moves as 45 out of a possible 50 steps and Donna saw the moves as 35 out of 50 steps. The family completed a second FAM III scale at the end of the session and waited to find out their results. Denise and Debbie were pleased that the scale showed change,

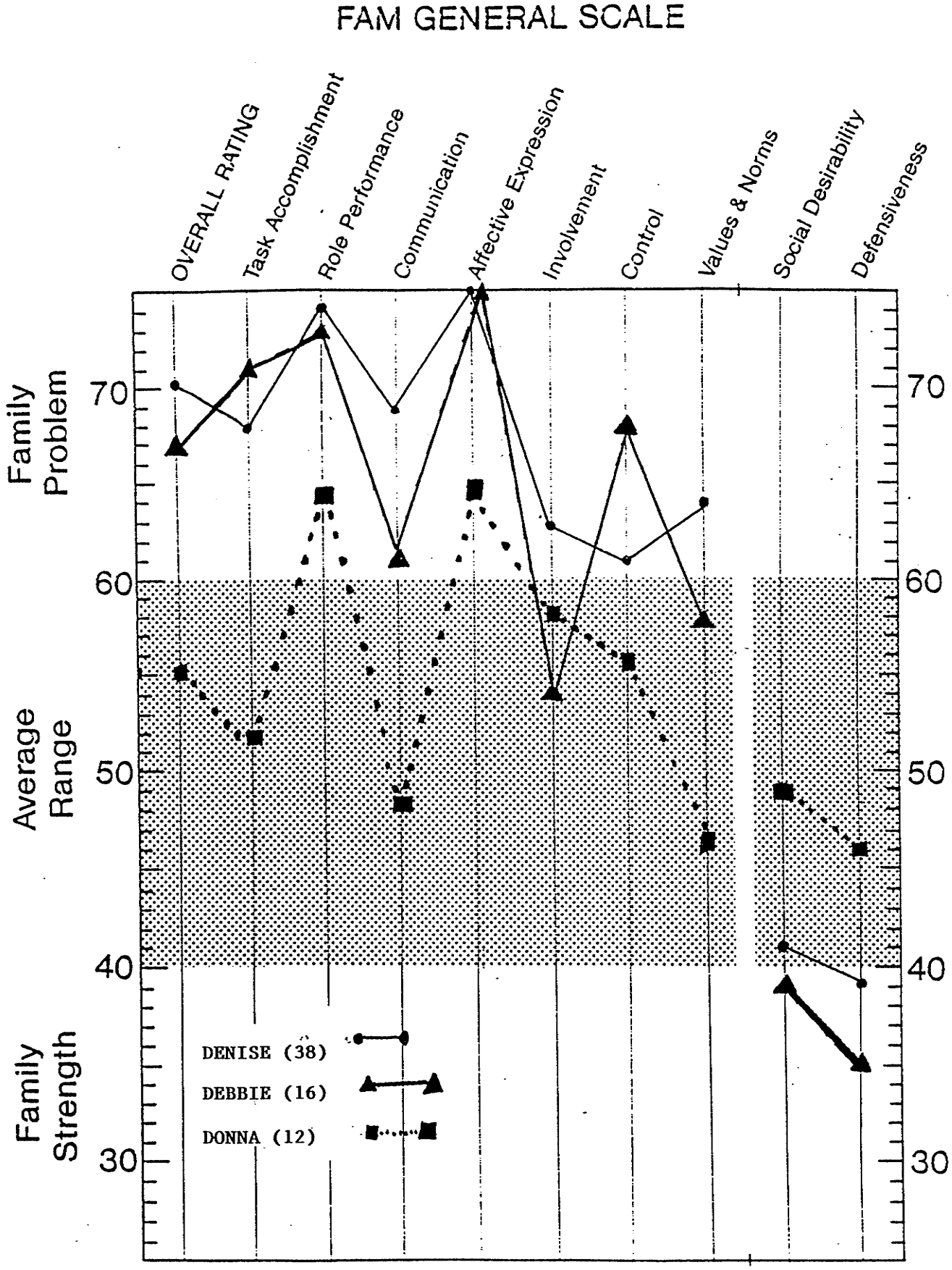
but discounted Donna's profile as they felt she had not answered the questions honestly. They left the session smiling and agreeing to continue work with George.

**INITIAL ASSESSMENT & DISCUSSION OF THE FAMILY ASSESSMENT MEASURE RESULTS (FAM III):**

The initial FAM III (see figure 1) results show extreme difficulties in the areas of Role Performance and Affective Expression. Denise and Debbie have similar scores/views on the functioning of the family. This closeness was observed in family sessions, to the point of the closeness smothering Debbie and preventing age-appropriate differentiation. Thus, Debbie had attempted to run away and threatened suicide to leave the family. Debbie's identified problems appeared to be a direct response to her own anger and/or fear of Daryll as well as wanting to protect her mother from Daryll's behaviour. Family problems appeared to be maintained by Denise's inability to take a firm stand regarding Daryll's family involvement while drinking. The result was not only frustration for the whole family, but also fear for their safety. Debbie was particularly fearful for her mother's safety.

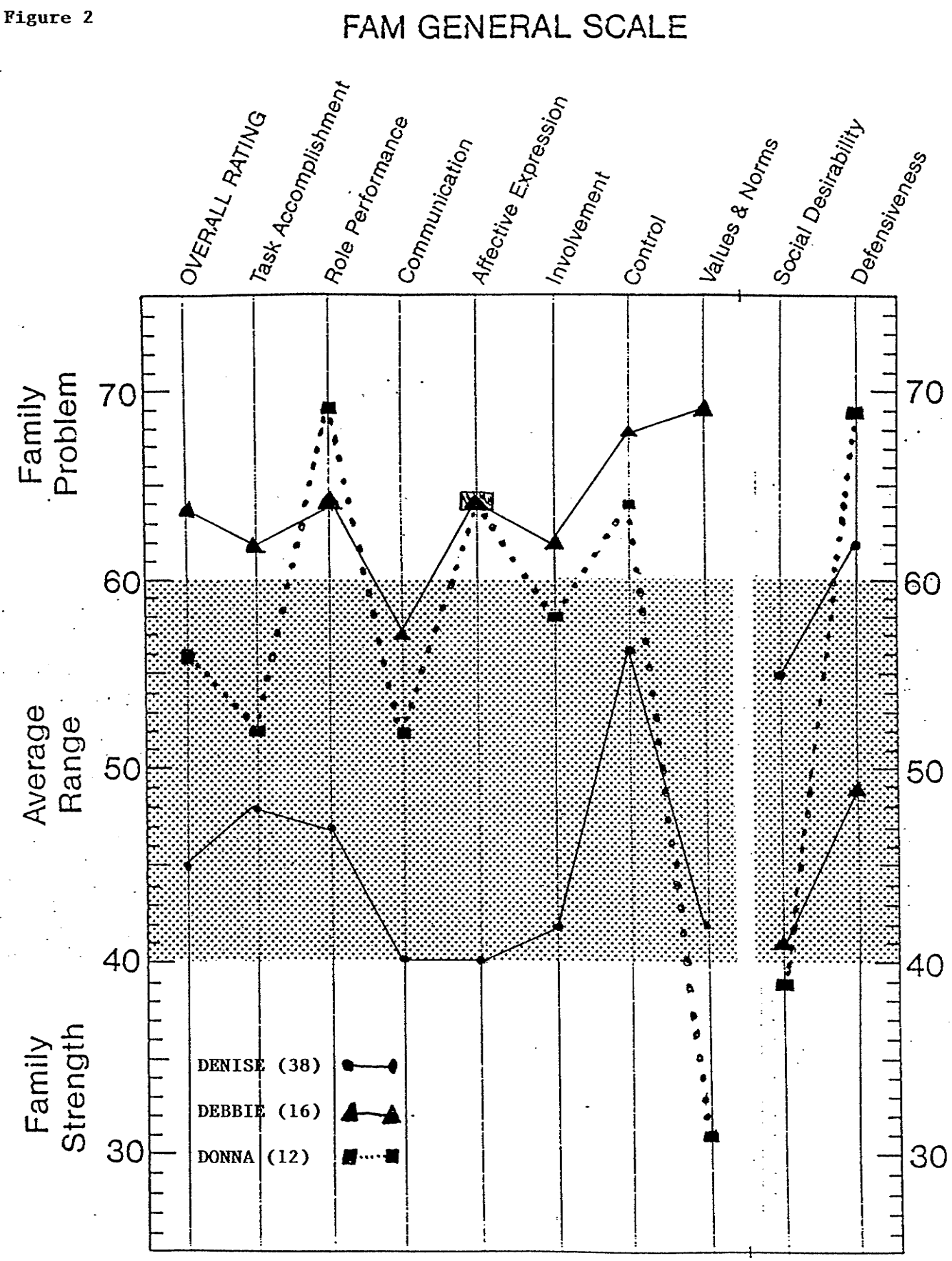
Figure 1






REID FAMILY: pre-treatment measure

Figure 2




REID FAMILY: post treatment measure

While the presenting problems focused on the disruptive behaviour of Debbie and Donna, the most serious problem expressed by the entire family was Daryll's drinking and violent behaviour. The two problems were influenced by one another and therefore needed to be dealt with in conjunction with each other.

The problem pattern was: mother pursues Daryll -> Daryll distances -> Mother engages Daryll to help discipline the girls -> Daryll and the girls fight -> Mother rescues the girls -> Daryll feels alienated and drinks -> Mother pursues Daryll; etc.

At the end of eight sessions Denise had made a clear stand with her daughters, but continued to have difficulty taking the same stand with Daryll. Denise showed a preference of playing hide and seek rather than forcing him to make a decision about their future.

**GOALS OF THERAPY:**

1. Help Denise take a stand on the intolerable behaviour of her daughters and Daryll.
2. Gently challenge Denise's world view regarding taking a stand with Daryll.
3. Help Debbie and Donna cooperate with their mother,

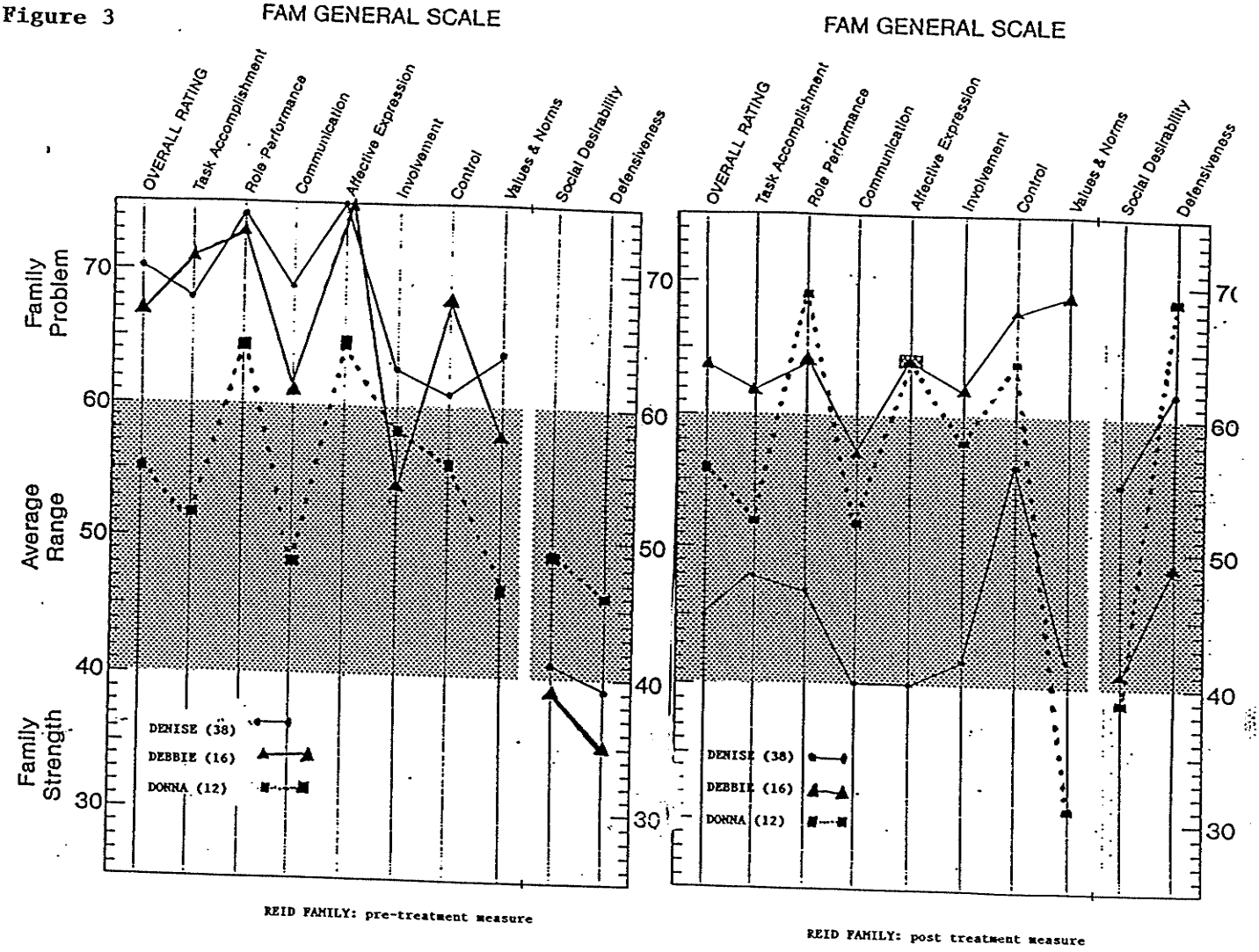
so that Daryll could not use them as his excuse to drink and be violent.

4. Validate and cement changes as they occur with Denise and her daughters.

**POST TREATMENT ASSESSMENT: COMPARISON OF PRE AND POST FAM III RESULTS:**

The most striking difference between the first and second FAM III scales (see figure 2 and 3) is the view Denise gives of the changes. Her overall rating moved from 70 in the pre-measure to 45 in the post-measure which shows her perception of the improvement in the family. Denise's scores on Defensiveness and Social Desirability shifted between the measures, but were still close to the normal range. The lower scores in the pre-measure show that her general profile may have been slightly inflated, and thus the extent of the problems in the family may have been slightly exaggerated. In the post-measure, her Defensiveness and Social Desirability scores are at the lower extremity of normal and therefore may reflect some exaggeration of how positive the changes in the family situation were. The post-measure scores of Denise are consistent with the observable progress shown by the family over the difficulties the

Figure 3




COMPARISON OF PRE AND POST TREATMENT SCALES

family presented when they entered therapy. Denise's view of the family shown in her post-measure scores is consistent with her presentation in the latter sessions of therapy. Her concern with "control" issues was consistent with wanting the best for her daughters, particularly Debbie as she began the process of growing up and leaving home, but in a more positive way than by running from problems. The shift in her satisfaction with "communication" and "affective expression" was consistent with the closeness and ease in which Denise and Debbie were able to generate throughout therapy.

Debbie's profile appears to be the most accurate, based on the consistency of her response style shown in the Social Desirability and Defensiveness subscales. In comparing her pre and post-measure Defensiveness and Social Desirability scores, it can be speculated that her low scores on the pre-measure indicate some "anxiety" on her part of what was the extent of the problems in the family. Therefore, the pre-measure would indicate some exaggeration as to the extent of the problems the family brought to therapy. The increase in her scores regarding Involvement, Control, and Values & Norms in the post-measure are consistent with the age appropriate struggles to differentiate that she engaged in with her mother in the latter stages of therapy. The

increase in these scores is consistent with her issues of "leaving home." In conjunction with the improvements her scores indicate in the remaining subscales, Debbie's profile shows a general increase in family functioning with the problems decreasing in their intensity.

Donna's profile has been deleted as a result of Debbie's stating that Donna had copied many of her answers. Her post-treatment profile was therefore inaccurate and of no use in evaluating changes in the family.

The shift in family view that occurred between Denise and Debbie throughout therapy was interesting in that in the pre-measure they agreed that there were a number of problems in the home. My perception of the shift, as shown in the post-measure scores, was that the initial struggle was viewed as involving Denise and her daughters. Both Denise and Debbie's scores show this struggle in the pre-measure. However, my interpretation of the positive shift shown in the post-measure on Denise's part continues to focus on the presenting problem between herself and Debbie. In that sense, the problem was much improved as evidenced by her scores. My interpretation of Debbie's post-measure scores is that she began to see the major family problems as existing

between Denise and Daryll, but also that her problem was how to "leave home" and the tasks involved in that process which are not nearly as drastic or devastating as the problems at the start of therapy.

**CONCLUSION:**

The Reid Family was one of only two families who completed pre and post treatment FAM III scales during my internship. My experience was that families would not fill out the scale after therapy. In general, therapy ended between sessions in that the family decided they had gone far enough or that therapy is not helpful and therefore they did not return. It is also possible that families could not see the utility in such a practice or that they may have been fearful of the scale not showing the changes they saw. Another factor in the limited number of post-treatment measures was that there was no opportunity in the practicum to gain the experience and learn the skills required in using these family assessment forms.

Through comparing pre and post treatment measures, it is apparent that pre-measures provide a useful indication of how families view their presenting problems, while post-

treatment measures enable the therapist to more accurately assess the pre-measure scores. In comparing the Reid Family scores I was able to understand the significance of the Social Desirability and Defensiveness scores as indicators of possible exaggerations in the remainder of family members' profiles. Pre-practicum experience in using the Family Assessment Measure could have enabled a more precise pre-measure assessment based on the profile scores.

In the case of the Reid Family, the FAM III was useful to both myself and the family in that it validated the changes which were observed in therapy. In spite of the remaining work to be done between Denise and Daryll, the family was able to see the initial problems with Debbie and Donna as having been successfully completed.

After transferring the case to George Enns, Denise contracted to work on her difficulties with Daryll, as the problem with the girls' behaviour no longer existed.

# CHAPTER FIVE

# CONCLUSION

## SECTION ONE

## THERAPEUTIC USE OF SELF

My expectation at the outset of the practicum was that I would learn the theories and the techniques of the Brief Solution Model. The assumption was that this learning would not only increase my level of competence as a therapist but that it would occur independent of personal growth and development. It was during supervision that the need to become congruent was pointed out as a pre-requisite to the intergration of theoretical knowledge and techniques in the Brief Solution Model. Congruence allows for neutrality, giving the therapist freedom to pursue issues with families that might otherwise be avoided for fear of rejection or fear of emotional backlash from the family toward the therapist. The resolution of personal issues enabled me to become more emotionally flexible whereby issues in therapy were no longer personalized and were less likely to contaminate therapy. This integration of a congruent self

was the groundwork to my therapeutic use of self. To illustrate this concept, three aspects leading to congruence are examined which contributed ultimately to achieving personal and theoretical integration.

The first aspect of gaining congruence was to address my pattern of compartmentalizing issues. Compartmentalizing was evident in my attempts to separate personal and professional learning and was also visible in my attempts to act in ways to please others. This compartmentalizing of issues resulted in my being incongruent, a condition which drained valuable energy. Harvey and Katz (1984) point out that when a person grows up seeking the approval of a parent, there is a tendency to displace this need for approval onto the people who judge them in adulthood. To overcome the need to compartmentalize I had to overcome the need for external approval.

The struggle to overcome the need for external approval meant reaching the point where my actions became based on what I believed and valued. The steps in this process were to become clear in my personal goals and then to move decisively toward those goals. Previously, I had reacted to what I felt others expected rather than in a way that was

based on my desires. While there was clarity in my professional goals, as noted in Chapter One, the process of becoming cognizant of and moving toward personal goals resulted in a more at ease and genuine approach to life and learning. This feeling of ease and genuineness, in turn, allowed for further professional learning.

The importance of theory and knowledge of family functioning is central to understanding how families understand their problems. How the therapist moves depends on how well he has integrated this theory with his own genuineness, sensitivity and spontaneity. The more integrated I became, the more I was able to identify with the struggles of the client and the less likely I was to muddy the waters with my own personal issues. This allowed sessions to be based on the family's best interest rather than personal validation.

The process toward congruence involved the development of an individual framework of life. Once I was able to gain some clarity and understanding about my own beliefs and expectations, I could then use my knowledge and experience as a framework of understanding to help families resolve their difficulties. It was crucial that the individual framework came from a position of care and concern and not

from a position of doing what I perceived as significant in what others expected from me.

I became able to see my personal struggles as steps in the process of change, and not as failures. The experience of becoming clear about my own life goals enabled me to be more sensitive and understanding of clients' situations and more confident that alternatives did exist for these families. The integration of knowledge and experience helped me to develop a more positive individual framework which resulted in therapy being less forced and more natural.

The third aspect in the move toward becoming congruent and ultimately to the therapeutic use of self was the need to take leadership. This issue was identified early on in supervision, along with the issues of compartmentalizing and the need to develop an individual framework of life. The importance of taking leadership was pointed out by supervisors to be as important in my personal life as it was in working with families because a therapist's personal and professional lives often mirror each other. As confidence and clarity grew personally, they also grew professionally, and vice versa. To take leadership, I had to examine my previous attempts to change patterns in my own life,

particularly those changes which produced desired outcomes as opposed to the changes in patterns which were reactions to avoid undesired outcomes. The skill and awareness of taking leadership in personal situations provided the confidence and became the groundwork for taking leadership in working with families. Leadership became more evident in sessions as I was not only able to maintain a focus which assisted the family toward problem resolution but also I was able to conduct more naturally paced sessions.

In addressing these aspects of becoming congruent described above, through a concentrated effort of being genuine rather than acting in ways to please others, I was free to learn and work in a more deliberate and focused way. It became easier to plan sessions and overcome obstacles presented by families. Personal issues still surfaced but through the experience of defining myself issues were overcome more quickly and from a more neutral position.

The process of overcoming personal issues provided me with personal experience in using the concepts of the Brief Solution Model. Supervision emphasized that the patterns of compartmentalizing, living in a way to please others, living with a reactive framework, and not taking leadership "were

not working" and resulted in my being incongruent. The challenge was to "try something different", to learn to behave in a way that was consistent with my personal beliefs and values without guessing what other people would say or do. With the experience of using the Brief Solution Model to overcome personal issues, I was more comfortable and committed to utilize it in my work with families.

Thus, my understanding of the therapeutic use of self has come to mean developing a congruent way of being from which I could validate the strengths of the family and assist them to find solutions to their problems. Through understanding and resolving the aspects to become congruent which included compartmentalizing, developing an individual framework of life and taking leadership, I was able to proceed with learning the theory of techniques and therapy to conduct sessions in a way which was strictly for the family's benefit.

# SECTION TWO

## CONCLUDING REMARKS

The four month practicum at MacNeill Clinic would probably best be described as four of the most growth producing months of my life. Growth personally and professionally occurred during the practicum. This chapter will highlight some of the changes which occurred as well as address the learning goals set at the outset of the practicum.

The discussion of the Therapeutic Use of Self only begins to show the personal growth which occurred through the resolution of becoming congruent which was begun during the practicum. The results of becoming congruent have been evident not only in my personal life, but also more importantly, show in my continued work with individuals and families. Struggling to gain an integrated use of self as a result of issues addressed in supervision helped meet the goal of becoming a therapist. While my skills in working with families were pointed out as strengths, supervision also provided the direction I had to go to begin to develop the theoretical understanding and confidence I desired as a therapist.

The move to develop an integrated therapeutic use of self resulted in a better understanding of how to complete therapy. Successfully concluding therapy became understandable once I was able to use myself in therapy to understand what families were struggling with in their reactions and attempted solutions to their presenting problem. The integration also addressed the goal of firming up my theoretical knowledge of family therapy and it opened the way to gaining practical knowledge in working with families.

As I became more integrated and congruent I gained confidence which had been lacking prior to arriving at MacNeill Clinic. Looking back on the experience, while writing this paper, I have come to realize how much of what I believed was based on the misconceived beliefs that I had to please others in order to please myself. But, as George Enns stated early in my practicum, "you impress more by being yourself than when you try to impress." It was only after addressing personal issues that the need to impress went away.

Through the practicum experience I was able to see the utility in the skills I had previously attained in learning

Structural Family Therapy. I have been able to incorporate them in my work with families using the Brief Solution Model. I have also come to the realization that the concepts of the Brief Solution Model, such as searching for exceptions and searching for solutions may eventually become incorporated into my future learning. In other words, learning never stops. The Brief Solution Model may be integrated into others models of therapy as I continue to learn.

As evidenced in the previous discussion of my use of measurement tools, specifically the Family Assessment Measure, it will be beneficial to gain more comfort in presenting it to families. Discomfort in the presentation as well as the need to be more decisive in attaining completed measures may account for the limited number of post-treatment measures which were completed during the practicum. It was unfortunate that I did not complete post-treatment measures with more families, but this is an area which I can continue to struggle with in the future.

I consider the practicum to have been a tremendous learning process both on a personal as well as a professional basis. I hope that this report can be useful to others who may use

the practicum experience for personal as well as professional growth. I would also encourage others to explore the Brief Solution Model for themselves as well as for families they work with.

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