TRAUMATIZED FAMILIES:

ASSESSMENT AND TREATMENT

BY

LINDA ANNE PERRY

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ABSTRACT

The treatment of trauma has generally focused on individuals rather than families. Since the 1980s, researchers and clinicians have turned their attention to the family system and family therapy has been recognized as an important intervention for traumatic stress. This study evaluated the efficacy of a short-term, intensive intervention approach for traumatized families using five case studies. Data was collected at three junctures, pre-treatment, post-treatment and at two month follow-up. Clinical interviews and self-report measures were used to collect data. Subjects were families seeking treatment for the trauma experienced by one or more family members. The intervention approach involved three assessment sessions and five treatment sessions.

The results suggest that four of the five families made at least some improvement over the course of treatment. One family clearly benefited from treatment, and three other families made some progress and agreed to attend further treatment sessions. Only one family withdrew from treatment, and they attended three assessment sessions and three treatment sessions before doing so.

The findings also suggest that over the course of treatment, symptoms of psychological distress and post traumatic stress disorder decreased for four of the seven parents in the study. Further, the internalizing and externalizing behaviours of eight of the ten children in the study were assessed by their parents to have decreased over the course of treatment.

In general, the results suggest that the treatment approach can be effective for traumatized families. However, at the conclusion of the treatment phase, three of the five families agreed to attend further treatment sessions. This suggests that the length of the intervention approach is

insufficient to promote sustained improvement in traumatized families. The results also point out methodological difficulties in evaluating treatment outcome and in relying on self-report measures of family functioning.

ACKNOWLEDGEMENTS

I am grateful to many people for their support and help with this thesis. I would especially like to thank the members of my Committee: Shirley Grosser; for her generous support and encouragement; Ruth Rachlis, for her warmth and for her insightful feedback; and Catherine Koverola, for her energy and the original thinking that was the motivating force behind this project.

Thanks to Dr. Koverola's research team, who provided unfailing practical and emotional support on all aspects of this project, which truly was a team effort. The ideas and thoughtful contributions of members of the research team enriched my experience as a researcher and made it deeply satisfying.

I want to thank the families who participated in this study, who made courageous and sometimes painful journeys as they struggled to deal with the impact of trauma, and who gave generously of their time and effort in completing questionnaires.

Thanks to the team of clinicians who participated in the study. Their cooperation in this project and their willingness to have their work evaluated is deeply appreciated. I also wish to thank my co-therapists, Cindy Hanna and Sue Nadon, with whom it was a pleasure to work.

Finally, thanks to my partner, Norm Larsen, for his loving support and encouragement throughout this project, and for his editorial assistance.

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Chapter 1

Introduction

Many families experience a traumatic event that results in a high level of stress, and disruptions of their life routine. Regardless of how many members of the family directly experience the traumatic event, all members of the family can be affected by it. The symptoms associated with a trauma sometimes cause a family to seek counselling or therapy services.

The research on traumatic stress has tended to focus on the impact of specific events, such as war, natural disasters, violence and terrorism, on individuals. More recently, researchers and clinicians have turned their attention to the impact of trauma on the family system, and family therapy has been recognized as an important intervention for stress caused by trauma.

The purpose of this study was to evaluate the efficacy of a short term, intensive intervention approach for traumatized families. The study makes a contribution to the body of knowledge respecting the treatment of traumatized families.

The study was part of a larger research project on the treatment of traumatized families carried out by Catherine Koverola Ph.D., C. Psych., Department of Psychology, University of Manitoba.

Rationale for the Study

I entered the Faculty of Social Work after working in the private and public sectors as a social researcher and policy analyst for 12 years. In making the shift from analyst to clinician, I hoped to incorporate my previous education and experience into clinical practice. However, I lacked a bridge that would facilitate the incorporation of my experience as a research and

policy analyst with my new career as a clinical social worker. The study that is presented in this thesis provided me with that bridge.

This occurred in two ways. First, my experience as an analyst and researcher did not include clinical evaluation. I had carried out evaluations of programs and policies and surveys of public opinion, but I soon learned in Social Work that clinical evaluation requires a different set of skills and knowledge. A clinical evaluator working with clients who are often distressed, must have clinical skills to recognize and deal with clinical matters when they arise. Clinical evaluation also requires that the needs of the client take precedence over the requirements of the research. The challenge is to design and implement a study that is as least intrusive into the lives of clients as possible, that does not create stress for the clients, or add to their level of distress, and that produces data that are valid and relevant to clinicians. This requires flexibility on the part of the researcher, and the ability to recognize any need for, and the impact of, modifications to the research procedures.

The second way in which the project bridged my past experience and my new career as a clinical social worker was in its placing me in the role of a scientist-practitioner, a role that links research and practice.

Traditionally, the roles of scientist and practitioner were quite separate. Researchers were often far removed from the clinical setting and the results of the research often had little bearing on the questions and concerns of practitioners (Rabin, 1981; Ross, 1981; Kazdin, 1982). Research was, and continues to be, conducted with groups of persons in order to meet the demands of traditional experimental design and statistical evaluation, in which the results are averaged (Kazdin, 1982). Bergin and Strupp (1970) suggest that the averaging of results in outcome studies has

weakened the results and not allowed for investigation of individual clients whose condition deteriorates over the course of treatment. This suggests that group designs might not be useful to a practitioner wanting to determine the effect of treatment on an individual client.

Concerns that clinical research has not always been useful in guiding clinical practice has lead some researchers to suggest that individual case studies may provide the best insight into understanding therapeutic change (Bergin & Strupp, 1970; Barlow, 1981). However, uncontrolled case studies are limited in the inferences that can be drawn from them on the role of treatment. It has been suggested that single-case research designs provide a viable alternative to uncontrolled case studies, and can bridge the gap between research and practice (Rabin, 1981; Kazdin, 1982; Penka & Kirk, 1991). A single-case research design can provide a practitioner with the tools to evaluate the effectiveness of his or her practice. The effect of treatment is evaluated by comparing different conditions presented to the same subject over a period of time. This type of design strengthens the case study, which strengthens the scientific inferences that can be drawn from them (Kazdin, 1981).

The study that is presented in this thesis provided me with the opportunity to increase my knowledge and understanding of traumatized families, and to enhance my clinical skills in treating families who have experienced trauma. In my practical work as a student of Social Work, I became conscious of the large number of people who are referred to therapy as a result of trauma. Based on my clinical experience and training, the approach I used with these clients was individual therapy. However, it soon became evident to me that in many cases this approach was too narrow. The client's progress in therapy could be undermined by the family

system, which was affected by the trauma. I felt that to be effective as a clinician I had to increase my knowledge about the impact of trauma on a family system, and to acquire skills to facilitate a healing process for families affected by trauma.

My role as a researcher in this study involved contacting families and screening them for eligibility, arranging appointments for an intake interview, greeting the families when they arrived for the interview, administering the pretest, posttest and follow-up measures to three of the five families, scoring the self-report measures for all five families, and coordinating the research activities with the clinicians. (Another member of the research team administered the measures to the two families for which I functioned as a clinician.)

My role as a clinician in this study involved working as a co-therapist for two of the five families in the study (Families #1 and #2). I worked with two different co-therapists. My role as a clinician was to carry out the family assessment, and to develop and implement a treatment plan for each family.

Learning Goals

My learning goals in carrying out this study were:

1. To develop and implement a single-case research design.
2. To increase my knowledge and understanding of the effect of trauma on the family system.
3. To increase my knowledge of treatment approaches for traumatized families.
4. To enhance my clinical skills in family therapy.

Research Goal and Objectives

The overall goal of the study was to evaluate the efficacy of a short-term, intensive treatment approach with traumatized families. The primary research objectives were:

1. To measure the effectiveness of the treatment approach in reducing the symptoms of traumatic stress on the individual members of a family.
2. To evaluate the impact of the treatment approach on family functioning.
3. To measure whether a change in one area of family functioning has an impact on other dimensions of family functioning.

Chapter 2

Review of the Literature

The Impact of Trauma on Families

The study of the impact of trauma on individuals has a long history (Herman, 1992). The impact of trauma on families has received much less attention. Families are a crucial component of the social context of family members who have experienced traumatic events. A family system affects and is affected by the traumatic experiences of its members. The experience of trauma is associated with the development of psychological symptomatology in individuals. However, not all individuals who experience trauma develop such symptoms. The literature indicates that one important factor that impacts on individual symptomatology is family functioning (Figley & McCubbin, 1983; McCubbin & Figley, 1983a; Figley, 1989a; Koverola, 1992; Hanna, 1993). Therefore, to fully understand the impact of trauma on the individual it is necessary to consider the impact of the trauma experience on the family system and the coping resources of the family.

Family Systems Orientation

Family therapy emphasizes the family system and the interactive processes that operate within that system to maintain the current patterns of behaviour. All models of family therapy are systemic in nature in that they recognize the interconnectedness of the individual, the family and the social environment (Guttman, 1991).

A family systems perspective conceptualizes a family as a group of interconnected individuals who form a system. The family system has subsystems that are separated by boundaries, and interaction across boundaries is governed by implicit rules and patterns (Kerr, 1981; Sayger,

1992). The major subsystems of a family are the spousal, parent-child, sibling and individual family members (Sayger, 1992).

Walsh (1982) identifies the basic assumptions that family systems orientation makes about the family system as follows:

1. Circular causality. The concept of circularity is basic to a systems orientation. It suggests that systems are constantly modified by recursive circular feedback from multiple sources from within and from outside the system. This means that causality is seen as circular rather than linear.

2. Nonsummativity. The family as a whole is greater than the sum of its parts. The family consists of not only individual family members, but also family organization and interaction patterns.

3. Equifinality. This principle suggests that the same origin may lead to different outcomes, and the same outcome may result from different origins. This suggests that the impact of an initial condition or event may be different for families, depending on family organization and interactional patterns.

4. Communication. All behaviour is regarded as communication, and everyday communication has two functions: a content or reporting function, which conveys factual information, opinions or feelings, and a relationship function, which conveys how the information is to be interpreted.

5. Family rules. Family interaction is organized by relationship rules that prescribe and limit the behaviour of individual family members. Rules operate as norms within a family, providing expectations about roles, actions and consequences, and influencing family values.

6. Homeostasis. The stability of the family is enforced by homeostatic mechanisms in the form of mutually reinforcing feedback loops, such as role complementary or reciprocal behaviour. This suggests that too great a

deviation from the family norm may be counteracted in the negative feedback process, reducing the tension and instability created by the deviation from the family's norm.

7. Morphogenesis. This principle refers to the flexibility that is required for a family to adapt to internal and external change. Normative transitions require that a family reorganize internally, which involves a shift in rules. Crisis events create high levels of stress in the family and require adaptational shifts for continuity of the family and the adjustment of individual family members.

A systemic perspective considers the individual within the context of his or her relationship system and the functioning of family members who comprise the system. Individual dysfunction is viewed to be symptomatic of current family dysfunction, and the symptoms of individual dysfunction are potentially functional and adaptive to the family system (Walsh, 1982). This suggests that an improvement in a family member's functioning can be a threat to the balance of the system.

Family Functioning

Family systems theory includes many concepts of healthy family functioning and dysfunctional family functioning. Barnhill (1979) has reviewed and presented a synthesis of these concepts. He identifies eight dimensions of healthy family functioning grouped under four basic family themes: identity processes, change processes, information processes and role structures.

Identity processes include the dimensions of individuation versus enmeshment and mutuality versus isolation. Individuation refers to the process by which family members experience independence of thought,

feeling and judgment, and develop a firm sense of autonomy, personal responsibility, identity and personal boundaries. The contrasting concept is enmeshment, which refers to a lack of differentiation among family members. A family that is described as enmeshed is one in which a member's identity is dependent on other family members. Boundaries are poorly delineated and family members strive for similarity of thought, feeling and judgment.

Mutuality refers to a sense of emotional closeness or intimacy between family members. Barnhill (1979) states that mutuality is possible only between individuals who have a clear sense of self that is differentiated from others. In contrast, isolation refers to alienation or disengagement from each other. Enmeshment can be associated with the isolation of family members when their identities become so close that mutuality is not possible.

The second theme identified by Barnhill is change. It includes the dimensions of flexibility versus rigidity and stability versus disorganization. Flexibility refers to a family's capacity to adjust and to be resilient in response to varied conditions and the process of change. Rigidity refers to a lack of tolerance for change and an inability to respond effectively to varied conditions. Stability versus disorganization refers to the level of organization and predictability of family interactions. Stability refers to consistency, responsibility and security in family interactions. In contrast, disorganization refers to a lack of stability and predictability and clear responsibility.

The third theme is information processing. This includes the dimensions of clear versus unclear or distorted perception, and clear versus unclear or distorted communication. A family that has clear perception is one that perceives events, such as conflict and affection, in a consensual

way. Unclear or distorted perceptions refers to confusing or vague perceptions between family members. Clear communication refers to a clear exchange of information between family members. In contrast, lack of clear communication refers to vague or confusing exchanges of information, paradoxical communication, or prohibitions against checking out the meaning of a message.

The fourth theme is role structuring, which includes the dimensions of role reciprocity versus unclear roles or role conflict, and clear versus diffuse or breached generational boundaries. Role reciprocity refers to clearly defined and mutually agreed upon role expectations that complement one another. When roles are unclear, the result is often confusion and conflict. Clear generational boundaries refers to the alliance of family members of the same generation such that the roles of that generation are clearly defined and separate from the roles of other generations, with the parents serving as the executives of the family. Diffuse boundaries refer to vague or unclear alliances that blur the differences between generations. Breached generational boundaries refers to alliances between members of two different generations against a member of a peer generation, such as a parent and child against the other parent.

The dimensions of healthy family functioning are interrelated. This interrelatedness suggests that change on one dimension of family functioning will have a reverberating impact on other dimensions (Koverola & Battle, in press). This is consistent with family systems theory, which asserts that for a system to maintain itself, change in one part of a system must correspond to changes in other components of the system.

Family Life Cycle

Family systems theory conceives of the family as moving through predictable developmental stages, in particular the addition and departure of members, that require the accomplishment of specific psychological tasks. This is referred to as the family life cycle. Several schemas have been developed to conceptualize the family life cycle, each of which identifies the major stages somewhat differently. The model developed by McGoldrick and Carter (1982; Carter and McGoldrick, 1989) provides a comprehensive and useful framework for clinicians. It views the family as comprising the entire family emotional system of at least three generations, and addresses issues such as the changing role of women in families, divorce and remarriage, and the impact of ethnic and cultural factors on the family life cycle.

The schema developed by McGoldrick and Carter (1982; Carter & McGoldrick, 1989) conceptualizes intact middle-class North American families as evolving through six stages: (1) the launching of the single, young adult (2) the new couple (3) families with young children (4) families with adolescents (5) launching children and moving on (6) families in later life. The psychological tasks that must be accomplished at each stage and common transition problems will be discussed.

The first stage, the launching of the single, young adult, requires that the young person accept emotional and financial responsibility for himself or herself. The primary task of the young adult is to come to terms with his or her family of origin. This requires that the young adult successfully separate or individuate from his or her family. Problems in this stage often center on either the young adult or the parents not recognizing the need to shift to a less hierarchical form of relating. Parents may encourage the young adult to

remain dependent, or the young adult may either remain dependent or rebel and break away from his or her parents but remain emotionally bound to them.

The second stage is the new couple. The primary task of the couple is the formation of the marital system, which requires the realignment of relationships with extended families and friends to include the spouse. Problems in this stage center on the failure to renegotiate family status. This is indicated by defective boundaries around the marital system. The new couple may cut themselves off too much, or experience intrusions from the extended family. It may also be that the partners are too enmeshed in their family of origins to form a new system.

The third stage is the family with young children. This stage requires that the couple adjust the marital system to make room for new family members. It also requires a realignment of relationships with the extended family to make room for the role of grandparents, and grandparents must shift to allow their children to be parents. Common problems in this stage are that parents struggle with each other about taking responsibility, or they refuse or are unable to fulfill the role of parents. This may be indicated when parents do not accept the generation boundary between themselves and their children. If the boundary is too weak the parents may complain that they are unable to control their children's behaviour. If the boundary is too strong, the parent may have adult-like expectations of their children.

The fourth stage is families with adolescents. This stage requires that the family boundaries become flexible to provide for the growing independence of children. Problems in this stage often stem from parents' resistance to providing the space the adolescent requires to experiment with independence. If the parents do not adjust the family's boundaries, the

adolescent may withdraw from involvement in age-appropriate activities, or the parents may feel ineffectual as parents.

The fifth stage is the launching of children and moving on. Carter and McGoldrick (1989) describe this stage as the longest and the most problematic. It requires renegotiating of the marital system as a dyad, developing adult to adult relationships between grown children and their parents, realigning relationships to include in-laws and grandchildren, and dealing with disabilities and the death of parents and grandparents. Problems in this stage can occur if parents have difficulty letting go of their children, which can lead to an overwhelming sense of loss, emptiness and depression.

The final stage is the family in later years. This stage requires a shift in generational roles. Problems can occur if older family members are unwilling to relinquish some of their power, or if they give up all their power and become completely dependent on the younger generation. Another source of problems is when the younger generation treats the older family member as incompetent or irrelevant.

The family life cycle is a useful framework to examine the impact of trauma on a family. Traumatic events always occur within the context of a particular stage in the family's development, and the flexibility and resources of an individual and family to cope with them vary with their developmental status (Hetherington, 1984). This suggests that the stage in the family life cycle at which the traumatic event occurs can affect the level of stress and disruption that results (Nichols, 1989; McGoldrick and Walsh, 1991). Normative events, such as the birth of a baby or the death of a spouse, are experienced as most stressful and disruptive if they occur at times that are inappropriate for that stage in the family's life cycle (Hetherington, 1984).

Traumatized Families

Two main sources of family stress are identified in the literature: normative transitions and traumatic or catastrophic events. Normative transitions are those that most families experience as they progress through the family life cycle, such as parenthood, the launching of children, and retirement (Carter and McGoldrick, 1989). They are scheduled events and transitions that occur in most families (Walsh, 1982). Sometimes normative transitions pile-up or cluster, and under certain conditions, can cause a family to experience a crisis by increasing their vulnerability and reducing their regenerative ability (McCubbin and McCubbin, 1989).

A traumatic event is defined in the Diagnostic Statistical Manual (DSM IIIR) (American Psychiatric Association, 1987) as "an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone". Traumatic events are described as: threats to one's life or physical integrity; threats or harm to one's children, spouse or other close relative or friend; natural or accidental disasters; or witnessing someone being seriously injured or killed. Unlike normative transitions, traumatic events often occur suddenly, giving the victims little or no time to prepare for them, and the victims often have had little or no experience with them (Figley, 1983). Depending on the magnitude of the event, it can disrupt the lifestyle and routine of survivors, cause a sense of destruction, disruption and loss, and leave the survivors with a detailed memory of the event.

Herman (1992) criticized the definition of a traumatic event in the DSM-IIIR for ignoring the frequency of these events. She suggests that events such as rape, battery and other forms of sexual and domestic violence are too common for women to be described as outside the range of

ordinary experience. She states that traumatic events are extraordinary because they overwhelm ordinary systems of care that give people a sense of control, connections and meaning, not because they rarely occur.

Koverola (in press) discussed the controversies that exist about the diagnostic criteria for post traumatic stress disorder (PTSD), and the proposed changes to the criteria for the DSM-IV. She states that three options have been proposed for the DSM-IV in relation to the stressor criterion, which has been criticized for being vague and unreliable: (1) providing a specific description of the nature of allowable stressors, (2) adding a subjective component to the definition by requiring that the stressor provoke a response in the person such as fear, helplessness or horror and (3) stating that the stressor must be exceptional.

The distinction between normative transitions and traumatic events is not always clear. Depending on the circumstances, an experience such as death or divorce may be either a normative transition or a traumatic event. Nichols (1989) notes that in the literature, divorce is described as both a normative transition and a traumatic event. He views both descriptions as accurate. McCubbin and Figley (1983a) view the differences between normative and traumatic events on a continuum. Depending on many factors, two families may have very different reactions to a similar event.

Walsh (1982) points out that a stressful event is distinct from the response by a family to the event. That is, the level of stress and disruption caused in the family relates not only to the nature of the event, but to other factors as well. Hetherington (1984) identifies these other factors as personal and family history, individual and family characteristics and resources, the social and physical context, and the interpretation or

appraisal of the event. She states that the interaction of these factors determines the level of stress that is associated with an event.

Figley (1989a, p. 5) defines traumatized families as those that are "attempting to cope with an extraordinary stressor that has disrupted their normal life routine in unwanted ways". He suggests that the stressor can be a seemingly minor incident or an extraordinary event, and one event or a series of events. The critical issue is not the stressor, but the "beliefs, points of view, perceptions, frames of reference, or cognitive appraisals of family members -- both separately and collectively" (Figley, 1989a, p. 6).

Figley (1989a) considers families in which one or more members are suffering from post traumatic stress disorder (PTSD) to be one subset of traumatized families. PTSD is a relatively new disorder in the psychiatric and psychological literature. It first appeared as a distinct diagnostic entity in the Diagnostic Statistical Manual (American Psychiatric Association, 1987) in 1980. As was mentioned earlier, the diagnostic criteria for PTSD in the DSM-IIIR are the subject of ongoing controversy, and changes have been proposed for the DSM-IV (Koverola, in press). Characteristic symptoms of this disorder include reexperiencing the traumatic event (eg., distressing recollections of the event, distressing dreams, a sense of reliving the event, or intense psychological distress in relation to events that symbolize or resemble the event), avoiding stimuli associated with the trauma or numbing of general responsiveness (eg., avoiding thoughts, feelings, activities or situations that are associated with the trauma, restricted range of affect, feeling detached from others), and hyperarousal (eg., difficulty falling or staying asleep, irritability, difficulty concentrating, hypervigilance).

How Families Experience Trauma

A traumatic event experienced by one or more members of a family can affect all members of the family. Figley (1989a) outlines four ways that family members experience trauma: when all family members experience the traumatic event (simultaneous effects), when the traumatic event strikes one member of the family with whom the family is unable to make contact (vicarious effects), when family members experience traumatic stress after making contact with a victimized member (chiasmal effects), and when the traumatic event occurs from within the family (intrafamilial trauma). The disruption of the routine life-style is most obvious when all members of a family experience a traumatic event (Figley, 1983). Family rules, roles and responsibilities change, and family members might find it hard to meet each other's needs. However, Figley (1983) states that a family that experiences a traumatic event together can be more useful to each other in dealing with it than if only one member of the family experiences the event. Survivors of a traumatic event can help each other to understand and accept it.

Secondary traumatization refers to the process by which other people who have an emotional connection with a trauma victim experience considerable emotional upset and may, over time, themselves become victims of the trauma (Figley, 1983). Figley (1983, p. 12) states that "...being a member of a family and caring deeply about its members makes us emotionally vulnerable to the catastrophes which impact them." Detrimental effects of trauma on significant others have been observed among the spouses and children of war veterans (Maloney, 1988; Rosenheck & Nathan, 1985; Solomon, Waysman, Levy, Fried, Mikulincer, Benbenishty, Florian & Bleich, 1992), the spouses and children of Holocaust survivors (Davidson, 1980; Freyberg, 1980), the families of rape victims (Feinauer,

1982), and the mothers victims of extrafamilial sexual abuse (McIntyre, 1993).

Trauma and Family Functioning

There is a small but growing body of empirical research and clinical literature that indicates a relationship between family functioning and a family's ability to cope with trauma. This research tends to focus on specific types of traumatic events, such as child sexual abuse, rape, divorce, illness, natural disaster and war. An exception to this is the work of Figley and McCubbin (1983; McCubbin and Figley, 1983b) and Figley (1989a). Figley and McCubbin (1983; McCubbin and Figley, 1983b) describe generic patterns of family adjustment to normative and catastrophic stress. They point out that these two sources of stress rarely operate in isolation, and that the stage of the family life cycle is reflected in how well a family can cope with a catastrophe. An important premise in the work of Figley and McCubbin (1983; McCubbin and Figley, 1983b) is that different types of stressors can have a similar impact on a family. They state, "...although the sources of stress may be different -- emerging from inside the boundaries of the family or imposed from outside -- the characteristic patterns of family reactions to stress are detectable across situations, family structures, and time" (Figley & McCubbin, 1983, p. 185).

The patterns of family reactions to stress described by Figley and McCubbin (1983; McCubbin and Figley, 1983b) relate to family organization and the family's definition of the event. Family organization refers to the level of integration and adaptability, and the family's definition of the event reflects their values and experience with traumatic events. Figley and McCubbin (1983; McCubbin and Figley, 1983b) suggest that functional

coping methods are universal and transcend all types and categories of stressors. They identify 11 universal characteristics that differentiate functional and dysfunctional coping (see Table 1, p. 20).

Empirical Research Related to Trauma and Family Functioning

Clinicians have long been aware of the role of family functioning in mediating the adjustment of trauma survivors. However, few empirical studies have investigated the relationship. A few studies have examined the relationship between a specific type of traumatic event, such as divorce, wife abuse, and child sexual abuse, and family functioning. The findings suggest that family characteristics can mediate the impact of traumatic events on individual family members.

Wolfe (1987) reviewed the empirical research on children of divorce and children of battered women. He concluded that the stress associated with a major life event lies more in their effects on family functioning and the resulting changes in the child's social environment than in the event itself. That is, the immediate stress associated with a major life event can play a lesser role in a child's adjustment and development than do the changes in the child's social environment as a result of the event.

In regard to child sexual abuse, several studies indicate the important role of family functioning in relation to trauma induction and the long-term adjustment of the child. The findings of a study by Friedrich, Beilke and Urquiza (1987) suggest that family variables were related to internalizing and externalizing behaviour in a sample of 93 sexually abused children. Significantly increased levels of internalizing and externalizing behaviour were related to greater family conflict and less family cohesion. Further, family variables were more significantly related to the problematic behaviour

Table 1

Characteristics of Functional and Dysfunctional Family Coping With Highly Stressful Events

Characteristics	Functional	Dysfunctional
Identification of the stressor	Clear, Acceptance	Unclear, Denial
Locus of the problem	Family-centered	Individual-centered
Approach to the problem	Solution-oriented	Blame-oriented
Tolerance of others	High	Low
Commitment to and affection for family members	Clear, Direct	Unclear, Indirect
Communication utilization	Open	Closed
Family cohesion	High	Low
Family roles	Flexible, Shifting	Rigid
Resource utilization	Balanced to High	Low to None
Use of violence	Absent	Present
Use of drugs	Infrequent	Frequent

Note. From "Bridging Normative and Catastrophic Family Stress" by Hamilton I. McCubbin and Charles R. Figley. In Stress and the Family. Volume I: Coping With Normative Transitions by Hamilton I. McCubbin and Charles R. Figley (Eds.), 1983, San Francisco: Jossey-Bass Publishers, p. 219.

than were variables related to the sexual abuse, such as severity and duration. Conte and Schuerman (1987) compared a sample of 369 sexually abused children with a sample of 318 non-abused children and found that the symptomatology of the victims was related to a supportive relationship with an adult or sibling and to the quality of family functioning. Victims who had a supportive relationship and whose families had few characteristics indicative of poor family functioning had significantly less symptomatology than victims who lacked a supportive relationship and whose family showed evidence of more severe family dysfunction. Variables related to the experience of the abuse explained only a small amount of the variance in the victims' functioning. Edwards and Alexander (1992) found that family characteristics, such as parental conflict, were related to the long-term psychosocial adjustment of women who were sexually abused as children over and above the effects of the sexual abuse. Women who had a history of sexual abuse were more likely to describe their families as having significantly more parental conflict than did women who had not been sexually abused. Higher rates of parental conflict in the family of origin were related to more psychological distress. Ray, Jackson and Townsley (1991) compared the family environment of female survivors of intrafamilial child sexual abuse, extrafamilial child sexual abuse, and women who had not been sexually abused. They found that the survivors of intrafamilial and extrafamilial child sexual abuse scored their families significantly lower on cohesiveness and organization, and somewhat lower independence, than did the nonabused group.

In summary, researchers have been attempting to explain why some victims of trauma are affected more than others. To date this question has not been answered (Conte, 1985), but there is evidence that family

functioning is a major variable that can explain the differential impacts of trauma on individuals and families. Because the definitions of family functioning used by researchers have varied, it is difficult to identify the family characteristics that can mediate the impact of trauma. Family characteristics that have been identified in the empirical research and clinical literature as mediators of the impact of trauma include family cohesiveness, family adaptability, family conflict, supportiveness, organization and independence of family members.

Models for Understanding Traumatized Families

Only two models are found in the literature that attempt to conceptualize the process of traumatization for families: Family Coping and Adaptation, and Family Adaptation to Trauma. A third model, the Comprehensive Model of Trauma Impact, provides a systemic perspective on trauma induction, and is useful for an understanding of the effect of interaction of individual functioning, family functioning, the community and society. Each of these models will be reviewed.

Family Coping and Adaptation

The most influential theory of family stress and coping processes has been the ABCX (crisis) model developed by Hill (1949) to explain the "roller coaster course of adjustment" to separation and reunion caused by war. Hill (1949) outlined a set of major variables and their relationships in a two-part framework. The first part described the period of crisis as follows: "A (the stressor event) -- *interacting* with B (the family's crisis meeting resources) -- *interacting* with C (the definition the family makes of the event) -- *produces* X (the crisis)" (Hill, 1958; p. 141). Hill (1958) classified stressors in terms of

their impact on the family. His classification scheme included four categories: 1) dismemberment -- a family structure changed by the loss of a member; 2) accession -- a family structure changed by the addition of a member; 3) demoralization -- the loss of morale and family unity; and 4) dismemberment or accession plus demoralization -- changed structure and loss of family morale and unity. Hill (1949) described the B factor, the family's crisis meeting resources in terms of family structure, identifying family integration and family adaptability as the major crisis meeting resources. The C factor, the definition the family makes of the event, was described by Hill (1949) as the meaning aspect of the crisis. Hill (1949) described it as the subjective definition the family has of the stressor, which reflects the family's value system and its experience with crisis.

The second part of the ABCX model is the process of family adjustment to crisis. Hill (1958) described the process as involving a period of disorganization, an angle or recovery and a new level of organization. The period of disorganization was described as "a downward slump in organization, roles are played with less enthusiasm, resentments are smothered or expressed, conflicts are expressed or converted into tensions that make for strained relations" (Hill, 1958, p. 146). A successful recovery requires the development of new routines and a minimum level of agreement among family members about the future.

Hill's ABCX model was modified by Burr (1973) to include concepts of family vulnerability and regenerative power. According to Burr (1973), the stressor event, the related family hardships (the amount of crisis caused by the stressor event), and the family's vulnerability to stress (the family's ability to prevent a stressor event from creating a crisis or disruption in the family system) influences the amount of crisis in the family system. The definition

the family makes of the changes influences the family's vulnerability to crisis. The variation in the family system's ability to recover from the disruptiveness resulting from a stress is explained by a family's regenerative power. Burr (1973) proposes that integration (common interests, affection and a sense of economic interdependence) and adaptability (the ability to change the structure or way of operating) are positively related to a family's regenerative power. That is, the more integrated and adaptable a family is, the better it is able to recover from disruptions. Burr's (1973) reformulation of the ABCX model is shown in Figure 1 (p. 25).

McCubbin and Patterson (1983) expanded the ABCX model by adding post-crisis variables. They called their model the Double ABCX. The central concept of the Double ABCX Model is family adaptation. Family adaptation is achieved through reciprocal relationships between individual family members, the family unit, and the community of which the family unit is a part. McCubbin and Patterson (1983) hypothesize that in a crisis situation, the family unit struggles to achieve a balance at both the individual-family and the family-community levels of family functioning. There is an interactive effect between these levels of family functioning. Therefore, changes in one level affect the other level. The Double ABCX Model proposes that the two major factors that determine adaptation are family demands and family adaptive resources. Family demands is what McCubbin and Patterson (1983) call "pile up". They suggest that families are seldom dealing with a single stressor, and that over time demands pile up. Family adaptive resources refers to the personal resources of each family member, the family system's internal resources, and social support. McCubbin and Patterson (1983) suggest that the characteristic that most influences a family's vulnerability to the impact of a stressful event is the general sense of

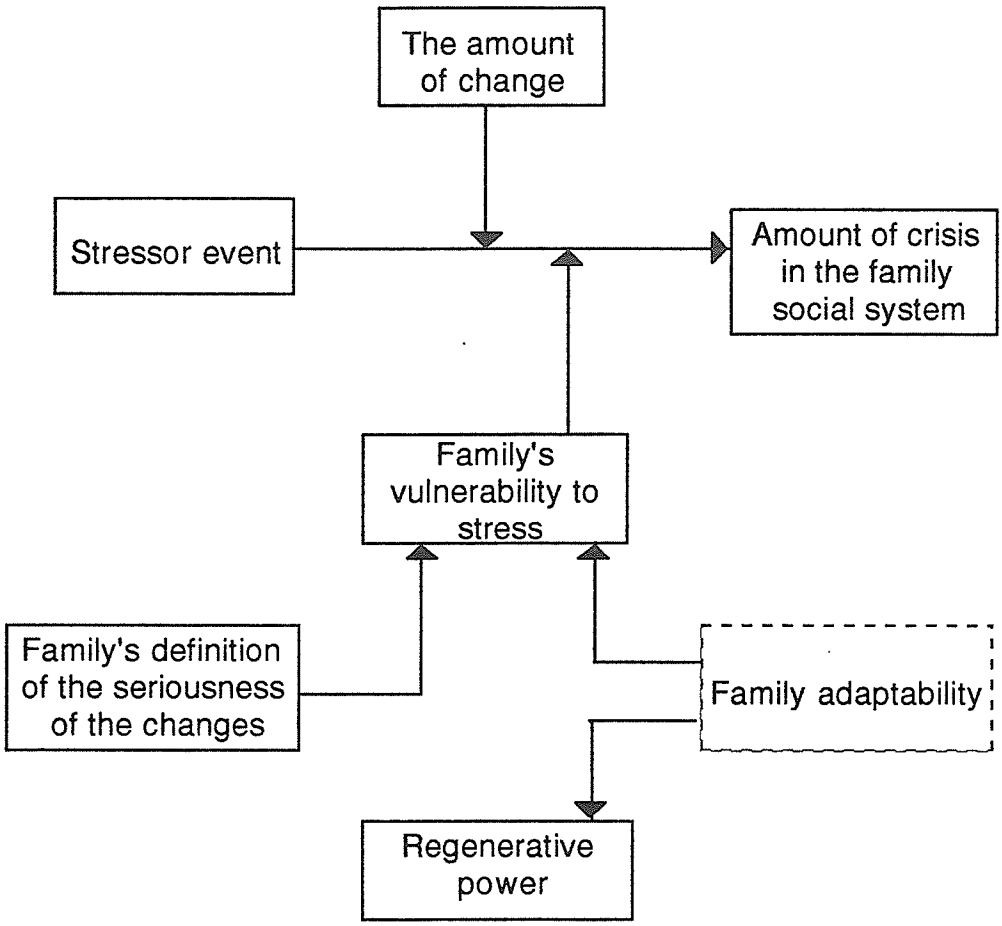

Figure 1. Burr modification of Hill ABCX model.

Note. From "Family stress and coping: A decade review", by McCubbin, H., Joy, C., Cauble, A., Paterson, J., Needle, R., 1980, Journal of Marriage and the Family, 43, p. 856. Copyrighted (1980) by the National Council on Family Relations, 3989 Central Ave. NE, Suite 550, Minneapolis, MN 55421. Reprinted by permission.

satisfaction and stability about the family structure and patterns of interaction.

The Double ABCX Model outlines two distinct phases by which families cope with stress. The first phase is the family adjustment phase. During this phase the family makes an effort to protect itself from change by maintaining its established patterns. The second phase is the family adaptation phase. During this phase the family realizes that it has to restructure, which may include modifications in established roles, goals and patterns of interaction.

Family Adaptation to Trauma

Figley (1989a) developed the model of family adaptation to trauma to explain the impact of traumatic events on families. He defined traumatized families as "those who are attempting to cope with an extraordinary stressor that has disrupted their normal life routine in unwanted ways" (p. 5). The Family Adaptation to Trauma model is based on the notion that the process of adapting to trauma is a continual process that can help or hinder current and future family functioning, or both. Intrinsic to this model is the idea that the stressful event and trauma do not occur simultaneously (see Figure 2, p. 27).

The stressor is defined as "an event or series of events that demands immediate attention to control" (Figley, 1989a, p. 24). Whether trauma occurs depends on the resources of the family and the perceptions about the stressor held by family members, especially the most influential members. An event becomes a "family traumatic event" when the family perceives that all or some of its members are in danger or involved in a major upheaval. This is the point at which the family begins to deal with the trauma. Post-

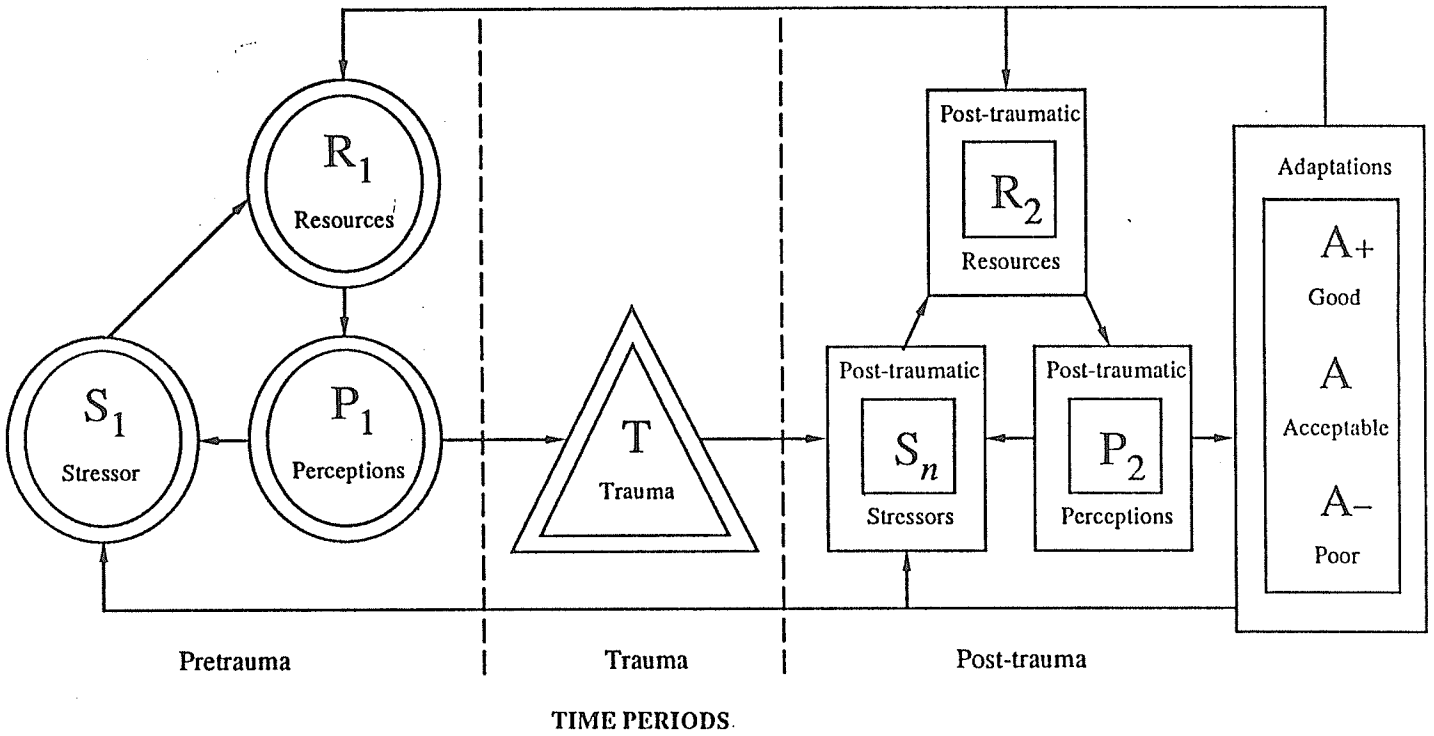

Figure 2. Systemic adaptation to trauma process.

Note. From Helping Traumatized Families (p. 25) by Charles Figley, 1989, San Francisco: Jossey Publishers. Reprinted by permission.

traumatic stressors are the accumulation of stressors and strains placed on the family system during and following the traumatic event. These can include the stress or event and its associated hardships, normative transitions, prior unresolved stressors, and the consequences of the family's efforts to cope.

Figley's (1989a) model proposes three possible outcomes to a family's process of adapting to the traumatic event - good, acceptable or poor. Good adaptation means that the family has benefitted from the experience in that their coping skills have been enhanced, which in turn leads to enhanced family resources that will prevent or assist the family to successfully cope with future stressors. Poor adaptation means that the family has chosen a strategy that has long-term negative consequences, such as the use of drugs or alcohol, or the use of violence as a means of gaining control. Acceptable adaptation is not defined.

Figley's (1989a) model of family adaptation to traumatic stress is based on a systems perspective. However, it is limited to the family system and does not address the influence of the larger systems in which the family is embedded (i.e. the community and society). It also does not give adequate consideration to the unique characteristics of individual family members and how this impacts on their adjustment to traumatic stress (McIntyre, 1993).

Comprehensive Model of Trauma Impact

The Comprehensive Model of Trauma Impact (CMTI) developed by Koverola (1992; in press) delineates the variables and contexts that are believed to be related to the impact of a traumatic event on an individual. This model can serve as a useful organizational format with which to

consider variables that have impacted on individual family members, and on the family unit. The model addresses four major areas: individual functioning, the nature of the trauma, the systemic context and the passage of time. Each of these areas identifies a number of interactive variables that impact on the individual and that therefore have the potential to mediate the impact of trauma (see Figure 3, p. 30).

The first area is individual functioning. This includes the six interactive aspects of development: affective, cognitive, interpersonal, moral, sexual and physical. Symptoms related to the experience of trauma can be evident in any of these areas.

The second area is the nature of the traumatic event. Characteristics of the event will vary, depending on the nature of the trauma. Generally they will include the type of trauma, its frequency and duration, the degree to which the individual was exposed to the trauma, and the age of the individual at the onset of trauma. Trauma is believed to impact on the interactive areas of the individual's development, and different types of traumatic events are thought to have a more powerful impact on specific areas of functioning.

The third area is the systemic context. This includes the family system, the community, and society. Each context has variables that can mediate the impact of the traumatic event. In the family system, family members' response to a traumatic experience, and family functioning (i.e., emotional environment, supportiveness, communication styles and permeable boundaries) can mediate the impact of a trauma on individual family members. In the community context, the impact of a traumatic event can be mediated by the reaction of other people, agencies and institutions, such as friends, church, school, and medical and law enforcement

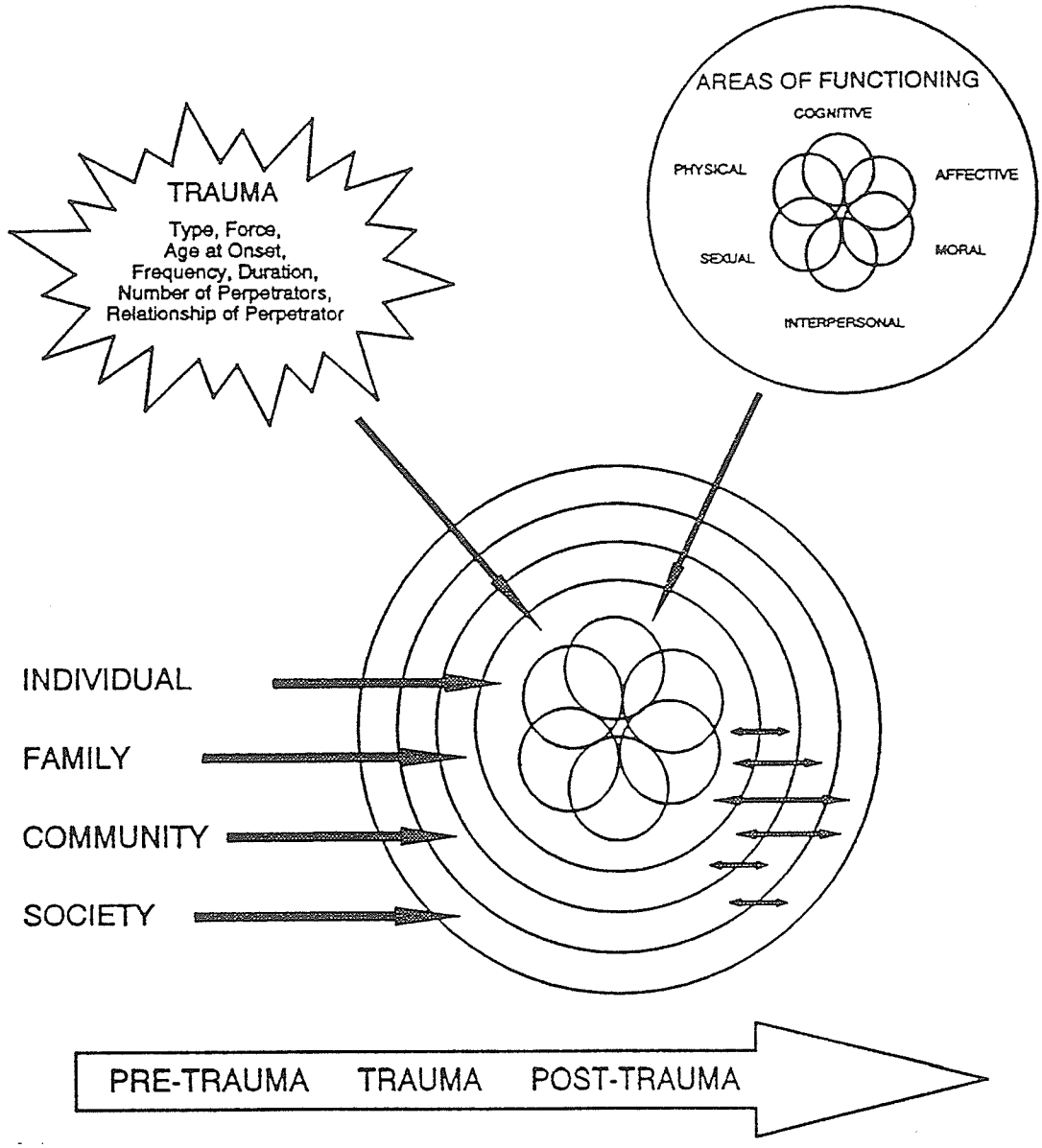

Figure 3. Comprehensive model of trauma impact.

Note. From "Psychological effects of child sexual abuse" by Koverola, C. In A. Heger and S. Emans (eds.) (p. 26) Evaluation of the Sexually Abused Child, 1992, N. Y.: Oxford University Press. Reprinted by permission.

personnel. The societal context refers to the underlying values and beliefs that determine how society responds to the type of trauma experienced. These values and beliefs are associated with how the family and the community react to the trauma.

The fourth area of the model is the context of time. Individuals and families are continually changing, and the passage of time can impact on the individual's adjustment to the experience of trauma. Therefore, it is important to consider where the individual or family is in the continuum of pre-trauma, trauma and post-trauma when assessing the impact of a trauma.

This model is useful for understanding the complex interaction of variables that influence how a traumatic event impacts on an individual and a family. It clearly illustrates the importance of examining the process of traumatization from a broad, systemic perspective.

Treatment Approaches for Traumatized Families

Although family therapy dates back to the 1950s, it was not used to treat traumatic stress until the mid 1970s (Figley, 1989a). There is a growing awareness of the value of family therapy as a treatment approach for traumatic stress, regardless of how many members of the family directly experienced the traumatic event (Feinauer, 1982; Pelletier & Handy, 1986; Figley, 1989a; Friedrich, 1990; Gil, 1993).

Only two descriptions of family treatment approaches for traumatic stress are found in the literature. However, it seems possible that the literature does not reflect the extent to which family therapy is being used to treat traumatic stress. For example, the Psychological Trauma Clinic at the St. Boniface Hospital in Winnipeg, Manitoba, provides services to children

12 to 17 years of age who have experienced a discrete trauma based on the criteria for PTSD in the DSM IIIR (American Psychiatric Association, 1987). While individual therapy is the predominant treatment approach, family therapy is provided if individual therapy is not successful in resolving the problem (S. Moscovitch, personal communication, August,1993).

The two treatment approaches for traumatized families that are described in the literature are the empowerment approach (Figley, 1989a) and the Franklian approach (Lantz and Lantz, 1991). Each of these approaches will be described.

Empowerment Approach to Treating Traumatized Families

The empowerment approach was developed by Figley (1989a). The fundamental goal of treatment is to empower families to enable them to recover on their own. This goal is achieved by utilizing the family system and the family's natural effort to recover from a traumatic event.

Figley (1989a) stressed the importance of assessing traumatized families to determine the family's level of stress and the coping resources it has available. He stated that traumatized families can be difficult to detect because they often seek help by presenting a problem that is different from the traumatic event. Figley's (1989a) assessment framework addresses both individual family member's symptoms and perspectives, and the systemic factors. Assessment techniques include the clinical interview and standardized paper-and-pencil measures of the trauma, stressors, the family's coping resources and their level of adaptation to trauma.

There are five phases to this approach. The first phase is building commitment to the therapeutic objectives. Figley (1989a) emphasized the importance of the commitment of all members of the traumatized family to

work with the therapist to reach agreed upon objectives. The second phase is framing the problem. The task of the therapist is to assist each family member to disclose his or her view of the problem. This provides the therapist with detailed information about reactions to the traumatic event. The third phase is reframing the problem. This occurs when the family discovers, or is introduced to a way of thinking about the experience, that is more tolerable and adaptable for family functioning. Post-traumatic symptoms are reframed to make them more manageable and more directly linked to the recovery process. The fourth phase is developing a healing theory. In the process of reframing various dimensions of the experience, the family can begin to reach a general consensus regarding the healing theory, which is a set of new perspectives on the experience. Figley (1989a) describes the healing theory as the "cure" for the family system. It provides a way to understand the current experience that allows the family to cope with and eliminate traumatic stress. The final phase is closure and preparedness. Figley (1989a) states that closure involves ensuring that the family has reached its treatment objectives and that the family members are prepared for future adversities.

Two of the treatment objectives that are crucial to a family's ability to cope with future traumatic events or stresses are building family social supportiveness and the development of new rules and skills of family communication. Family social supportiveness is the extent to which family members support each other on five dimensions: emotional support, companionship, advice, tangible aid, and encouragement. He cautions against focusing on these objectives too early in treatment, and suggests that many families will not be ready to work on them until the last phase when the presenting symptoms have been addressed.

The empowerment approach to treating traumatized families is based on the model of family adaptation to trauma, which proposes that a family's resources and perceptions of the stressor event determine whether a trauma occurs (Figley, 1989a). A strength of this approach is that it is adaptable to various types of traumatic events. A further strength is a very thorough assessment process, which uses clinical interviews and standardized measures to gather information about individual and family functioning. Figley (1989a) emphasizes the importance of monitoring the progress of treatment with standardized measures. He recommends that the measures be readministered every eight to ten sessions, and six months after treatment.

An assumption of this treatment model is that the family was functioning effectively before the trauma occurred (Figley, 1989a). Based on that assumption, treatment focuses more on the experience of trauma than on family functioning. Only two areas of family functioning are addressed in treatment: social supportiveness and communication. It is assumed that once the family has a new, more adaptable way of understanding the traumatic event, their natural coping resources will be available to them. The assumption that the family was functioning effectively before the traumatic event has not been tested empirically. Figley (1989a) does not indicate how long it takes to treat traumatized families using the empowerment approach, but he implies that the process is long-term rather than short-term. The empowerment approach has not been subject to empirical testing.

Franklian Treatment with Traumatized Families

This treatment approach is based on the theory that the experience of trauma disrupts the family's search for meaning in life and creates an existential vacuum (Lantz & Lantz, 1991). If the vacuum is not filled with a developing sense of meaning, it could be filled with problems and symptoms, such as depression, substance abuse, sexual dysfunction and emotional numbness. The goal of treatment is to assist the family in the search for meaning. Lantz and Lantz (1991) describe three treatment activities: network intervention, social skills training, and existential reflection.

Network intervention is used to decrease a family's social isolation by increasing "meaning opportunities" in the family's social environment. Social skills training teaches the family new communication and problem-solving skills that can strengthen the family's ability to make use of meaning opportunities in the external environment and within the family. Existential reflection is the process of helping family members to bring repressed meanings into family awareness. The therapist does this through questions, comments, empathy, interpretations and sincere interest in helping the family. Lantz and Lantz (1991) indicate that repression can keep a family from experiencing not just the pain of trauma, but also the "meaning potentials" that are embedded in the trauma. Therefore, an important component of treatment is to help the family remember experiences of trauma in order to facilitate the recovery of meaning.

There are five stages to this treatment approach. The first is establishing a treatment system. This involves developing trust in and commitment to the treatment process. The second is remembering the trauma. The therapist helps family members to remember the details of the

traumatic event, and to discover that all family members have been affected by the trauma. The third stage is recovering the meaning in the trauma. This involves assisting family members to find a way to reframe the experience of trauma as a meaning opportunity. Family members' memories of the experience can be useful in helping the family to find meaning in specific symptoms. The fourth stage involves making use of meaning potentials. It is suggested by Lantz and Lantz (1991) that making use of the trauma is most effective if it occurs through a "self-transcendent giving to the world", which can transform survivor's guilt into survivor's responsibility. The final stage of treatment is terminating and celebrating. This should occur after the new family meanings have been accepted and integrated into the life of the family.

This treatment approach focuses almost exclusively on the experience of trauma. The implicit assumption is that the family was functioning effectively before the traumatic event occurred. Treatment addresses only two areas of family functioning: communication and problem-solving skills. Lanz and Lanz (1991) describe the treatment process as lengthy, citing case examples in which treatment lasted for almost three years. Given the pressure on therapists today for treatment to be not only effective, but also efficient in terms of time and resource (O'Hare, 1991), the long-term nature of treatment is a limitation.

Conceptualization and Measurement Issues in Family Research

Since the early 1970s, there have been many advances in family research (Marcos & Draper, 1990). However, the identification, conceptualization, and measurement of family constructs continue to be difficult issues for researchers.

The conceptual issues faced by family researchers focus on the unit of analysis. Larsen and Olson (1990) suggest that there is often a blurring of individual and couple/family variables in family research. They state that it is dangerous to assume that one member of a family can adequately represent the family's reality, and it is equally problematic to conclude that the acquisition of several respondents' data can provide a more valid reality. The extent to which individual impressions can help us to understand family level processes, or the accuracy of composite data from individuals in defining family characteristics, is uncertain. Relationship variables go beyond summing individual impressions. Ransom et al. (1990,p. 49) suggest that family researchers must be careful to avoid making a "Type III error", which they define as drawing a conclusion based on inappropriate data. They state that researchers have to be clear about the unit of interest, the unit of analysis, and the unit being measured. It is not uncommon that the unit being measured is the individual and the unit of interest is the family. Ransom et al. (1990) state that great caution must be exercised in drawing conclusions about a family as a functioning system from data collected from individual family members.

Family research also faces many methodological issues. Larsen and Olson (1990) state that self-report measures are the most common method for collecting data in family research. However, these authors identify two major limitations of self-report procedures. The first is the exclusion of some members of the family because of an inability to answer questionnaires, such as children, "handicapped members", and "older individuals". The second limitation is an incapacity to measure all types of variables. Certain variables may be more sensitive to subjective data collection procedure, and others may be more sensitive to objective data collection procedure.

The authors suggest that the ideal is to have a variety of both subjective and objective methods.

In a discussion of the reliability and validity of self-report measures, L'Abate and Bargarozzi (1993) suggest three main problems with using self-report measures as a criterion in evaluating family therapy. First, consumer satisfaction can be confused with objectively measurable changes. Second, the self-reported satisfaction may be independent or even negatively related to objectively measured change. Third, self-report information should be compared with other measures of change rather than considered alone. The authors suggest a multidimensional method that consists of nonoverlapping measures of different dimensions of the variables being measured.

A second methodological issue relates to discrepancies in the data collected from different members of the same family. Inevitably, data collected from different family members will differ. Information from individual members of the same family may be analyzed by combining the scores in some way, or by comparing and contrasting the scores between family members. Both options derive a score from individual responses that stands for the unit. Larsen and Olson (1990) caution against creating composite scores, which they suggest have some important liabilities that are often ignored. For example, they state that calculating an average or mean score assumes that all members' perceptions are equally valid. This might be acceptable in respect of some variables, but questionable for others. Larsen and Olson (1990) suggest that it is possible that some members of a family are more "accurate" than others in specific types of assessment. Composite scores or averages can mask important differences between family members.

Chapter 3

Treatment Approach and Method

Treatment Approach

The treatment approach evaluated in this study was developed by Koverola and Battle (in press). Based on the premise that family functioning impacts directly on the ability of family members to cope with trauma, the goal of the approach is to improve family functioning. An important premise of family systems theory is that change on one part of a system necessitates change on other parts of the system. This premise suggests that an intervention that impacts on one dimension of family functioning can lead to changes on other dimensions of family functioning and on the functioning of individuals in the family. It is assumed that change in one area will have a reverberating effect, and will result in change in other areas. Because this approach involves targeting only one area of family functioning for intervention, it is intensive and short-term.

The treatment approach involves an assessment phase and a treatment phase. The primary goal of the assessment phase is to gather information about the family and the problem they are experiencing in order to develop an understanding of how the family and individual family members are functioning. The family's level of functioning is assessed on each of the eight dimensions described by Barnhill (1979): individuation versus enmeshment, mutuality versus isolation, flexibility versus rigidity, stability versus disorganization, clear versus unclear or distorted perceptions, clear versus unclear or distorted communication, role reciprocity versus unclear roles or role conflict, and clear versus diffuse or breached generation boundaries. Based on information obtained in the assessment, a treatment plan is developed that targets one dimension of

family functioning for intervention. The dimension that is targeted is determined by examining patterns of the family's strengths and weaknesses, as well as the malleability of each dimension. This is a judgment made by the clinicians. The treatment plan is presented to the family at the conclusion of the assessment.

Treatment involves the therapists directly intervening on the targeted area of family functioning. The nature of the intervention varies according to the area targeted and the needs of individual family members. During the treatment phase, all areas of family functioning are monitored to ensure that any change that is occurring is in the desired direction.

The treatment approach of Koverola and Battle (in press) was designed for a broad range of problems families bring to therapy. To evaluate the efficacy of this model to treat families who have experienced trauma, the assessment was expanded to include the four major areas outlined by the Comprehensive Model of Trauma Impact (Koverola, 1992; in press): individual functioning, the nature of the trauma, the systemic context (i.e. family functioning, social supports and resources), and the passage of time. A description of the nature of the information gathered and the self-report measures used for each of these areas will be outlined.

Individual Functioning

Assessing the symptomatology of individual family members includes assessing adult family members for the symptoms of PTSD and psychological distress, and assessing the children for general behavioural disturbance and sexual behaviour. The self-report measure used to assess PTSD was the Trauma Sequelae (Koverola, Proulx, Hanna, Battle, and Chohan, 1992). Psychological distress in adults was measured with the

Brief Symptoms Inventory (BSI, Derogatis and Spencer, 1982). General behavioural disturbance in children and adolescents was measured by the Child Behavior Checklist - Parent Report Form and the Child Behavior Checklist - Adolescent Report Form (CBCL, Achenbach and Edelbrock, 1983). Sexualized behaviour was measured using the Child Sexual Behavior Inventory (CSBI, Friedrich, Grambsch, Damon, Koverola, Hewitt, Lang and Wolfe, 1992).

Nature of the Trauma

The type of the information gathered about the traumatic event varied, depending on the nature of the event. Generally, it included the nature of the event, when it occurred, duration, which family members directly experienced the event, how each member of the family perceived the traumatic event, and the impact it had on individual family members and the family system. The clinical interview was the primary method for gathering the information. The Trauma Sequelae also provided information on the impact of the traumatic event on individual adult family members.

Systemic Context

The systemic context includes family functioning and social supports. The assessment of family functioning focused on the eight dimensions identified by Barnhill (1979). Three self-report measures were used to assess family functioning: Family Adaptability and Cohesion Evaluation Scale (FACES III, Olson, Porter and Lavee, 1985); the Family Characteristics Scale (Koverola and Battle, in press), and the Family Environment Scale (FES, Moos and Moos, 1986).

A further dimension of family functioning that was assessed related to family life cycle and previous experience with transitions. A genogram was constructed with each family and detailed information was obtained about the family's history and the developmental history of each child.

Information on the families social supports and resources were obtained through the clinical interview. This included information about relationships with extended family and friends, school, community groups and professionals that are accessible to the family for assistance with decision-making, practical tasks, emergency assistance and social activities. The amount of support that the family had, and their willingness and ability to access the resources available to it was assessed in the clinical interview.

Passage of Time

Information was obtained from the family to determine where the family was on the continuum of pre-trauma, trauma and post-trauma. This included information on when the traumatic event occurred, how long it lasted, and when it ended.

The approach of Koverola and Battle (in press) for treating families is similar to Figley's (1989a) empowerment approach and Lanz and Lanz's (1991) Franklian approach in that it is adaptable to various sources of traumatic stress that a family experiences. Like the empowerment approach, in involves a comprehensive assessment and uses standardized measures to monitor progress. It differs from these approaches in some important ways. First, it focuses primarily on family functioning rather than on the experience of trauma. Second, it is designed to be short-term rather than long-term.

The goal of the present study was to measure the efficacy of the short-term, intensive treatment approach for traumatized families.

Method

Subjects

The subjects in this study were five families self-referred to the Community Resource Clinic (CRC) for family therapy. The reason for referral included a reference to a traumatic event that was experienced by at least one member of the family.

Family Therapists

A co-therapy approach was used to assess and treat the client families. The principal investigator was a co-therapist in two case studies. Co-therapists were nine graduate students in psychology and social work, including the author of this thesis. The clinical work was supervised by the principal investigator of the larger research project, Catherine Koverola Ph. D., C. Psych.

Measures

1. Family Functioning. Three questionnaires were used in this study to measure family functioning: the Family Adaptability and Cohesion and Evaluation Scale (FACES III, Olson, Porter and Lavee, 1985), the Family Environment Scale (FES, Moos and Moos, 1986), and the Family Characteristics Scale (Koverola & Battle, 1993).

a) Family Adaptability and Cohesion Evaluation Scale. This is a 40-item self-report measure of family functioning. There are two 20-item scales:

one assesses perceived levels of family cohesion and adaptability, and another assesses desired levels of functioning. The discrepancy between the two scales indicates the level of family satisfaction. This measure is suitable for use with nuclear, blended, and single parent families. It is also relevant to families with different cultural and ethnic backgrounds because the family serves as its own norm base. That is, the measure assesses the level of satisfaction of each member of the family with the current family system (Olson, 1986). Since scores between family members tend to vary considerably, the recommendation of the authors was followed and the FACES III was administered to each adult member of the family.

FACES III has adequate internal consistency (.62 for adaptability, .77 for cohesion, and .68 for total score). It has very good face and content validity, and it discriminates well between problematic and non-symptomatic families (Olson, 1986).

b) Family Environment Scale. The FES is a 90-item scale that was designed to measure the social-environmental characteristics of all types of families. It comprises 10 subscales: cohesion, expressiveness, conflict, independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation, moral-religious emphasis, organization, and control. The FES was completed by the adult members of each family.

The internal consistency of the 10 subscales ranges from .61 to .78. Test-retest correlations for the individual subscales are reported to range from .68 to .86 after 2 months, .54 to .91 at 4 months, and .52 to .89 in a 12 month follow-up study (Moos and Moos, 1986).

c) Family Characteristics Scale. This is a new measure that was developed for this study. It measures each of the eight dimensions of family functioning described by Barnhill (1979) (see Appendix A).

2. Symptomatology. Five measures were used in this study to assess individual symptomatology. Two of the measures assess adult family member's symptomatology: the Brief Symptom Inventory (BSI, Derogatis and Spencer, 1982) and the Trauma Sequelae (Koverola, Proulx, Hanna, Battle & Chohan, 1992). Three measures assess the symptomatology of adolescents and children: the Child Behaviour Checklist - Youth Report Form and the Child Behaviour Checklist - Parent Report Form (CBCL, Achenbach and Edelbrock, 1983), and the Child Sexual Behaviour Inventory (CSBI, Friedrich, Grambsch, Damon, Koverola, Hewitt, Lang & Wolfe, 1992).

a) Brief Symptoms Inventory. The BSI consists of 53 items that evaluate psychological symptoms experienced within the previous week. It was used to assess the level of psychological distress experienced by adult family members. It provides information on the nature and intensity of a person's emotional distress (global severity index), and the pattern of symptomatology along nine dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. It was chosen because of the breadth of symptomatology covered.

The BSI has good reliability (.68 to.91 test-retest at two week intervals; Cronbach's alpha coefficients equal .71 to .85) and construct validity. It is recommended as being sensitive to treatment interventions,

stressful and traumatic life events, and mental disorders, with norms available for college-aged and adult non-patients, out-patients, and in-patients (Cochran and Hale, 1985; Derogatis and Melisaratos, 1983; Figley, 1989a).

b) Trauma Sequelae. The Trauma Sequelae is a 23-item questionnaire that measures post traumatic stress disorder (PTSD) symptomatology, and is based on DSM IIIR criteria. Although the measure is still in the process of being validated, some preliminary evidence of its concurrent validity is available. Hanna, Koverola, Proulx and Battle (1992) investigated the incidence of PTSD in a sample of 833 female university students and found that 6 percent of the subjects met the criteria for PTSD. These results were validated by administering the Structured Clinical Interview for the DSM IIIR - Nonpatient Edition (SCID-NP) to a subset of 45 subjects. Chi-square analysis of the results indicated no significant differences in the way that the Trauma Sequelae and the SCID-NP classified individuals as either PTSD positive or PTSD negative (see Appendix B).

c) Child Behavior Checklist - Parent Report Form. The CBCL - Parent Report Form is a 138-item checklist that measures parents' perceptions of emotional and behavioural problems in their child. It measures factors such as the amount of anxiety, depression, somatic complaints, hyperactivity, aggressiveness, and delinquency. It is suitable for use with parents of children between the ages of 4 to 16 years of age.

The CBCL has good test-retest reliability (.82 to .97). Inter-parent agreement for the behaviour problem, and the externalizing and

internalizing subscales has been reported to range from .40 to .75, .55 to .77, and .19 to .77, respectively. Variability was greatest between parents' reports of their female children. This measure has good construct and criterion-related validity, and stability data indicate that the measure is sensitive to change over 3, 6 and 18 month intervals with coefficients generally decreasing over time for the behaviour problem scale (Achenbach and Edelbrock, 1983).

d) Child Behavior Checklist - Youth Report Form. The CBCL - Youth Self Report is a 112-item checklist designed to obtain self-ratings from 11 to 18 year olds on behaviour problems. Most of the items in the checklist are in the same format as the CBCL - Parent Report Form, except that the items are worded in the first person.

The validity of the CBCL - Youth Self Report has not been extensively tested. Preliminary research indicates good stability in self-ratings by clinically referred youths over a six month period, and lower, but statistically significant agreement with ratings by parents and a clinician (Achenbach and Edelbrock, 1983).

e) Child Sexual Behavior Inventory. The CSBI is a 36-item checklist, completed by a caregiver, which assesses a wide variety of child sexual behaviour. It was designed to expand on the few items pertaining to sexual behaviour that are included in the CBCL and the Louisville Behaviour Checklist (Friedrich, 1992). In an extensive normative project undertaken on the measure, 880 children aged one to 12 with no history of sexual abuse were compared to 260 sexually abused children. The clinical sample was derived from sites in California, Minnesota and Canada. The results show

that the CSBI discriminates between the sexual behaviour of children who have been sexually abused and children who have not been sexually abused (Friedrich, Grambsch, Damon, Koverola, Hewitt, Lang & Wolfe, 1992) (see Appendix C).

3. Client Satisfaction. The Client Satisfaction Questionnaire was designed for this study to measure client satisfaction with treatment. It includes 2 four-point Likert type questions to measure client satisfaction with the services received, and it provides room for comments (see Appendix D).

Research Design

The study involved five single case studies. Data were collected at three measurement points, before treatment, after treatment and a two month follow-up. At each measurement point, data on adult symptomatology, child behaviour and family functioning were gathered through clinical interviews and self-report measures. As well, at the beginning and end of treatment the therapists working with each family assessed the family's level of functioning using the Family Characteristics Scale. Five families were involved in the study.

The data for each family were examined and compared for the three measurement points.

Procedure

Recruitment and Screening

Families seeking family therapeutic services at CRC were interviewed by telephone and screened with a questionnaire to determine whether they were eligible for the clinical research study (Appendix E). The inclusion

eligibility criterion was that at least one member of the family must have experienced a traumatic event. Consistent with Figley (1989a) and Herman (1992), a traumatic event was defined as an event that is extraordinary and that would be markedly distressing to almost anyone. A traumatic event is extraordinary, not because it rarely occurs, but because it overwhelms ordinary systems of care that give an individual a sense of control, connection and meaning. Exclusion eligibility criteria were as follows: pending criminal or family court proceedings, a substance abuse problem by one or both parents, the primary caregiver was a foster parent, and, in the case of child sexual abuse the perpetrator resided in the home.

Once it was determined that a family met the eligibility criteria and was interested in participating in the research study, an intake interview was scheduled. At the intake session, the study was discussed with all family members and they were asked to sign a consent form (Appendix F).

Assessment

A total of three assessment sessions, including the intake interview, were carried out. The clinical interview was used to gather information on the family history, and a genogram was developed with each family.

Upon completion of the assessment, a detailed assessment report was prepared that included a formulation of the family's problem and a treatment plan. This was presented to the family at the next session, and the family was asked to contract for five treatment sessions.

Pretest

In addition to clinical interviews, self-report measures were used to gather information from family members. The measures were administered

to family members by a clinically trained member of the research team. The planned procedure was to administer the measures to family members immediately before the intake interview. However, the first family to attend an intake session seemed somewhat uncomfortable with this procedure. A decision was made to reverse the order, and administer the measures immediately after the intake interview. This procedure was used with the second family to attend an intake session, and it did not seem to create any discomfort for the family. The last three families to attend an intake session requested to complete the measures at home. It was determined that family members were capable of completing the measures on their own, and their request was granted.

The information obtained from the measures provided baseline data upon which to monitor any changes that occurred during treatment. Further baseline data on family functioning were obtained from the therapists' scoring of the family's level of functioning on the eight dimensions using the Family Characteristics Scale.

Treatment

As discussed earlier, treatment focused on facilitating change on the targeted dimension. A variety of interventions were used. Some sessions included all family members, while others included only the parental subsystem or the sibling subsystem. A total of five treatment sessions were carried out.

All sessions were video-taped with the knowledge and consent of the families.

Posttest

The posttest measures were administered between the last treatment session and the termination session. The measures administered in the pretest were readministered, and family members were asked to complete the Client Satisfaction Questionnaire. Families were given the option of completing the posttest measures at the Clinic, or having the researcher come to their home. All families chose the later. Some families requested to complete the measures on their own, but two families required the assistance of the researcher.

Termination

At the termination session, therapists provided the family with feedback on treatment outcome based on posttest measures and clinical assessment. Further treatment was recommended for some of the families.

Follow-up

About two months after the posttest, a follow-up session was scheduled. The self-report measures, with the exception of the Client Satisfaction Questionnaire, were administered. The researcher administered the measures to clinets in their home, or family members completed them on their own. Families were offered a follow-up session with the therapists to review their situation.

Chapter 4

Results: Case Studies

The results for each of the five families who participated in the research project will be discussed separately. The author was a co-therapist for the first two families. Therefore, the course of treatment will be described in more detail for the first two families.

Family #1

Description

This was a blended family with five children, including the mother's three daughters from two previous relationships (aged 11, 9 and 7), and the couple's two sons (aged 2 1/2 and 15 months). The parents had been married for 4 years. (A genogram appears in Figure 4, p. 65)

Presenting Problems

The presenting problem was a high level of stress and conflict within the family that was manifested in arguing and yelling. Especially troublesome to the parents was the high level of conflict among their three daughters. The two oldest daughters had received short-term crisis intervention services for suicide ideations shortly before the family was referred for family therapy.

The father presented as depressed and withdrawn. The mother presented as anxious and overwhelmed. The oldest daughter presented as withdrawn and sad; she spoke very little in family sessions. The two younger daughters were lively and actively participated in discussions. The 2 1/2 year old son presented as fussy, aggressive and very demanding, and there were observable delays in the areas of sensory/motor and speech

development. He had temper tantrums during the interview. The baby presented as a passive infant.

Description of Traumatic Experience

The family had a history of chronic trauma. The mother had a previous relationship that was abusive, and one of the children was sexually abused by her biological father when she was 20 months old.

In the four years the parents had been married, the family had experienced numerous traumas including unemployment, severe financial hardship, a long and costly custody dispute, and an inter-provincial move.

Both parents had experienced trauma in their childhood. The father described his family as alcoholic and abusive. The mother was an only child whose parents divorced when she was 3 years old. She lost contact with her biological father when she was 11 years old.

Formulation

Based on the results of the assessment, generational boundaries were identified as the target area for intervention. This area was chosen for three reasons.

First, diffuse generational boundaries seemed to be having a damaging effect on all family members. For example, one child was parentified and had a lot of responsibility for the care of her siblings. At times, she was also her mother's confidant. A second child was a scapegoat, and was constantly criticized by both parents. The marital relationship seemed to be weak. The father reported difficulties with intimacy and attachment as a result of his childhood experiences. Finally, there was a high level of sibling rivalry.

The second reason for targeting generation boundaries was that the family was entering the stage in the family life cycle in which an important task is to redefine the parent-child relationship, particularly in regard to autonomy, responsibility and control (Carter & McGoldrick, 1989). The family would have to learn to accommodate the older children's need for increasing levels of independence. It was anticipated that this would pose a problem for the family because of the enmeshment and rigidity in family functioning.

The third reason for targeting generational boundaries was that it was judged to be malleable and amenable to intervention. Family members openly acknowledged some of the problems that are indicative of diffuse generational boundaries, such as sibling rivalry and the parentification of one child.

Course of Treatment

Following the three assessment sessions, the family was seen for five treatment sessions and a termination session. The parents attended an additional seven treatment sessions following the termination session. The goal of treatment was to reinforce generational boundaries. The treatment plan focused on strengthening the marital and sibling subsystems as well as fostering appropriate separation between these subsystems. An overview of the treatment plan is in Table 2 (p. 66).

Several interventions were used to achieve the goal. To strengthen the marital subsystem, the therapists attempted to increase the level of communication and emotional closeness of the parents. They were asked to carry out homework assignments that required them to spend time together

sharing their feelings, and learning to meet each other's need to feel cared about.

An intervention with the parents that was targeted at strengthening the boundaries between the parents and their children was to explicitly request the parents not to discuss sensitive or potentially embarrassing issues in the presence of their children. They were helped to understand the potential impact on the children of hearing these discussions.

To strengthen the sibling subsystem, the three oldest children attended a session without their parents. The therapists engaged the children in activities designed to improve their relationships with each other, such as learning to recognize each other's positive characteristics, and complimenting each other.

The final intervention, family sculpting, was used to assist the family to understand family relationships and family dynamics. The parents and the three girls were present at the session. Two approaches were used. The first approach involved the physical placement of family members. Family members were sculpted in the order that they joined the family. The sculpture started with the mother. She was joined by her three daughters. The father joined the mother and her three daughters, followed by the couple's two sons. Some interesting dynamics emerged during the exercise. First, before the father joined the family, the mother was close to her three daughters, particularly the oldest daughter. However, after the father joined the family, the oldest daughter distanced herself from the family. Second, the birth of the boys resulted in the two youngest daughters distancing themselves from the family. At the same time, the oldest daughter moved closer to the family, and very close to her little brothers.

The second approach to sculpting involved representations of family members with plasticene figures. Each family member made a representation of themselves out of plasticene, and the younger daughters made representations of the two little boys, who did not attend the session. Each of the girls was asked to assemble the plasticene figures. First, they were asked to illustrate how they see their family now. Second, they were asked to illustrate how they would like their family to be. The most significant dynamic to emerge from this exercise was that each of the three girls clearly indicated a feeling of emotional distance from the family, and expressed a desire for closer relationships between family members.

At the last session, the family's progress was reviewed with them, and it was recommended that the parents continue in couple therapy to work on relationship issues and parenting skills. Following the termination session, the family experienced a further series of traumatic events, including the death of a member of the father's family, the father's loss of employment, and the mother undergoing surgery. After a six week break, the parents continued therapy with different therapists. They attended only two sessions between the termination session and the follow-up.

Data

Family Functioning: Mother

Three measures of family functioning were used in the study: Family Adaptability and Cohesion Evaluation Scale (FACES), Family Environment Scale (FES) and the Family Characteristics Scale.

FACES measures perceived and ideal levels of cohesion and adaptability. With respect to cohesion, the findings for the mother indicate that she perceived family cohesion to increase slightly from a moderate level

in the pretest, described as connected, to an high level in the posttest, described as enmeshed. This increase was sustained in the follow-up. The mother's view of an ideal level of cohesion for her family, according to FACES, was in the high end of the scale at all three measurement points (Figure 5, p. 67).

With respect to adaptability, the data indicate that the mother perceived her family's level of adaptability (i.e., the extent to which the family system is flexible and able to change) to decrease slightly over the course of the study. It decreased from a moderate level in the pretest and posttest to the low end of the scale (i.e., rigid) in the follow-up. The mother's view of the ideal level of adaptability for her family also decreased over the course of the study, moving from the high end of the scale, described as chaotic, to a moderate level, described as flexible (Figure 5, p. 73).

The findings from the FES indicate relatively substantial increases in the subscales measuring expressiveness (i.e., the extent that family members are encouraged to act openly and to express their feelings directly), intellectual-cultural orientation (i.e., the degree of interest in political, social, intellectual and cultural activities), and control (i.e., the extent to which set rules and procedures are used to run family life). There was also an increase between the posttest and the follow-up on the subscale that measures independence (i.e., the extent to which family members are assertive, self-sufficient, and make their own decisions) (Table 3, p. 68).

The Family Characteristics Scale was the third measure of family functioning. The data from this measure suggest that the mother's perception of her family, on each of the dimensions measured, varied little over the course of the study. The only exception was the dimension of

stability versus disorganization (i.e., the level of organization and predictability in family interactions). The data suggest that the mother perceived her family to be slightly less stable in the posttest than she did in the pretest. However, the follow-up data suggest a relatively significant improvement (Figure 6, p. 69).

Family Functioning: Father

The findings from the FACES indicate that the father perceived his family to have a moderate level of cohesion and adaptability at all three measurement points. It is interesting to note that his notion of an ideal level of family cohesion increased from a moderate level in the pretest, to the high end of the scale (i.e., enmeshed) in the posttest and the follow-up (Figure 7, p. 70).

With respect ot adaptability, the findings from FES suggest that, from the pretest to the posttest, the father perceived increases in the subscales that measured conflict (i.e., the amount of openly expressed anger, aggression and conflict among family members), achievement orientation (i.e., the extent to which activities are cast into an achievement-oriented or competitive framework), active-recreational orientation (i.e., the extent of participation in social and recreational activities), and control (i.e., the extent to which set rules and procedures are used to run family life). The findings also suggest that the father perceived that his family's level of organization (i.e., the degree of importance of clear organization and structure in planning family activities and responsibilities) had decreased from the time of the pretest to the posttest, then increased substantially at the time of the follow-up (Table 4, p. 71).

The findings from the Family Characteristics Scale, suggest that at the time of the pretest, the father perceived family members to be very isolated from each other. However, he indicated in the posttest and follow-up that family members had become emotionally closer to each other so as to have a strong sense of mutuality. The findings also indicate that the father perceived the family's level of stability to deteriorate from the time of the pretest to the time of the posttest, then to improve and return to the pretest level in the follow-up (Figure 8, p. 72).

Symptomatology: Mother

Two measures were used to assess the symptomatology of the parents, the Brief Symptoms Inventory (BSI) and the Trauma Sequelae.

The findings from the BSI indicate that the mother had a relatively low level of psychological distress at all measurement points. However, the Global Severity Index, which is the most sensitive of the three global indices, indicates that her level of distress was slightly lower in the posttest than in the pretest, and then increased substantially in the follow-up (Table 5, p. 73).

The findings of the Trauma Sequelae, which measures post traumatic stress disorder (PTSD), indicates that at the time of the pretest, the mother met some of the criteria for PTSD and was classified as "partial PTSD" (see Appendix H). Most of these symptoms had remitted by the time of the posttest and the improvements were sustained at the time of the follow-up.

Symptomatology: Father

The findings for the father in regard to the BSI indicate that he had relatively low levels of psychological distress at all three measurement

points. However, the Global Severity Index suggests that his level of distress increased substantially in the follow-up (Table 6, p. 74).

The findings from the Trauma Sequelae do not suggest that the father had symptoms indicative of PTSD, or partial PTSD, at any of the three measurement points.

Symptomatology: Children

The Child Behavior Checklist-Parent Report Form (CBCL) and the Child Sexual Behavior Inventory (CSBI) were used to measure the symptomatology of the three oldest children in the family. These measures were completed separately by the mother and father.

The findings from the two main scales of the CBCL are presented. These are internalizing behaviour, described generally as fearful, inhibited and over-controlled behaviours, and externalizing behaviours, described generally as aggressive, antisocial and under-controlled behaviours (Achenbach and Edelbrock, 1983).

The findings from the CBCL completed by the mother suggest that she perceived the internalizing and externalizing behaviours of each of the three children to decrease from the pretest to the posttest, then to increase quite substantially in the follow-up (Figures 9a & 9b, pp. 75-76).

The findings from the CBCL, completed by the father, also suggest substantial decreases in internalizing and externalizing behaviours for child #1. In regard to child #2, the findings suggest that internalizing and externalizing behaviours increased from the pretest to the posttest, then decreased substantially from the posttest to the follow-up. The findings for child #3 suggest that externalizing behaviours decreased substantially from the pretest to the posttest, and increased slightly in the follow-up. He

perceived the internalizing behaviours of child #3 to remain at a low level throughout the course of the study (Figures 10a & 10b, pp. 77-78).

The findings pertaining to the Child Sexual Behaviour Inventory, completed separately by the mother and father for each child, are not suggestive of any problematic sexual behaviours.

Client Satisfaction

At the time of the posttest, the parents were asked to complete a short questionnaire that measured client satisfaction. The mother indicated that she was mostly satisfied with the services her family had received, and that she would use the services again if she was in need. The father was less satisfied than the mother, indicating that he was mildly dissatisfied and that he did not think he would use the services in the future if he were to seek help. Both parents indicated that they felt the children's problems did not receive enough attention.

Clinicians' Impressions of the Outcome of Treatment

The clinicians who worked with this family judged treatment to be somewhat successful. They perceived that some progress was made in strengthening the marital subsystem, and in strengthening the boundary between the marital/parental subsystem and the sibling subsystem.

The data from the Family Characteristics Scale that was completed by each of the clinicians at the beginning and end of treatment, suggest that the clinicians perceived some change to occur in family functioning over the course of treatment. However, their perceptions differed in regard to the areas of family functioning that changed. Clinician #1 indicated slight improvement on the dimension of clear versus distorted communication

patterns, and slight deterioration on the dimensions of flexibility versus rigidity, and stability versus disorganization, both of which represent the family's ability to cope with change. The findings also suggest a deterioration on the dimension of role reciprocity versus unclear roles. The data from clinician #2 suggest slight improvements on the dimensions of clear versus distorted perceptions, and clear versus weak generational boundaries. A slight deterioration was suggested on the dimension of stability versus disorganization of family interactions (Figure 11, p. 79).

Summary of Family #1

The presenting problem of this family was a high level of conflict between the three oldest siblings. The assessment identified that the marital relationship and the family's generational boundaries were weak. The parent's had difficulty fulfilling their executive role, one child was parentified, and another child was scapegoated. The family presented as chaotic. The mother presented as anxious and overwhelmed. The father presented as depressed and distant.

The area of family functioning targeted for intervention was generational boundaries. The treatment plan involved strengthening the marital and sibling subsystems, and the boundaries between the subsystems.

The clinicians judged treatment to be somewhat successful. They felt that some progress was made in strengthening the marital subsystem, and in strengthening the generational boundaries. The parents reported that they were communicating more and feeling closer to each other. Generational boundaries seemed to be strengthened. This was accomplished, at least in part, by shifting the focus of the problem from the

children to the marital relationship. However, at the termination session (Table 2, p. 66, Session 9), the parents continued to express concern about the children's behaviour, and the father continued to scapegoat one of the children. The goal of strengthening the sibling subsystem was largely not achieved. This was due to the short-term nature of the treatment, and insufficient time to address parenting issues.

The data from the self-report measures indicate that the mother and father had somewhat different views of the functioning of their family. The mother's responses to FACES suggest that she considered an extremely high level of cohesion (i.e., enmeshment) to be ideal. The father indicated a moderate level of cohesion to be ideal in the pretest, but in the posttest and follow-up he suggested that an extreme high level is ideal. In the pretest, the mother also indicated that an extremely high level of adaptability (i.e., chaotic) was ideal. This decreased to a more moderate level in the posttest and follow-up.

The father's responses in the FES and the Family Characteristics Scale suggest that he perceived the family's level of organization and stability to decrease substantially from the pretest to the posttest. This was discussed with the family in the termination session. The father's follow-up data suggest that he perceived substantial improvements in those areas following that discussion.

The self-report measures of psychological distress suggest that the mother's level of psychological distress, as measured by the BSI, decreased in the posttest, then increased substantially in the follow-up. The father's level of psychological distress also increased substantially in the follow-up. This is probably explained by the fact that within this time period, a member of the father's family died and the mother underwent surgery. The family

once again faced the father's unemployment shortly after the follow-up data were collected.

The parents' perceptions of changes in their children's behaviour over the course of treatment differed. The mother perceived their behaviour to improve in the posttest, then deteriorate substantially in the follow-up. In contrast, the father perceived the oldest child's behaviour to improve at each measurement point, and the second child's behaviour to deteriorate slightly in the posttest, then improve in the follow-up. He perceived the internalizing behaviours of the third child to be at a low level at each measurement point, and her externalizing behaviour to decrease substantially. The mother generally perceived the children's internalizing and externalizing behaviour to be more problematic than did the father.

Overall, treatment for this family cannot be judged to be successful. While some progress was made in the first five treatment sessions, it was not sustained in the two month follow-up. The short-term treatment model was insufficient to accomplish the goals. The couple accepted the recommendation of the therapists and attended a further seven treatment sessions and a termination session. However, the family continued to experience traumatic events over the course of treatment, and their progress in therapy was limited.

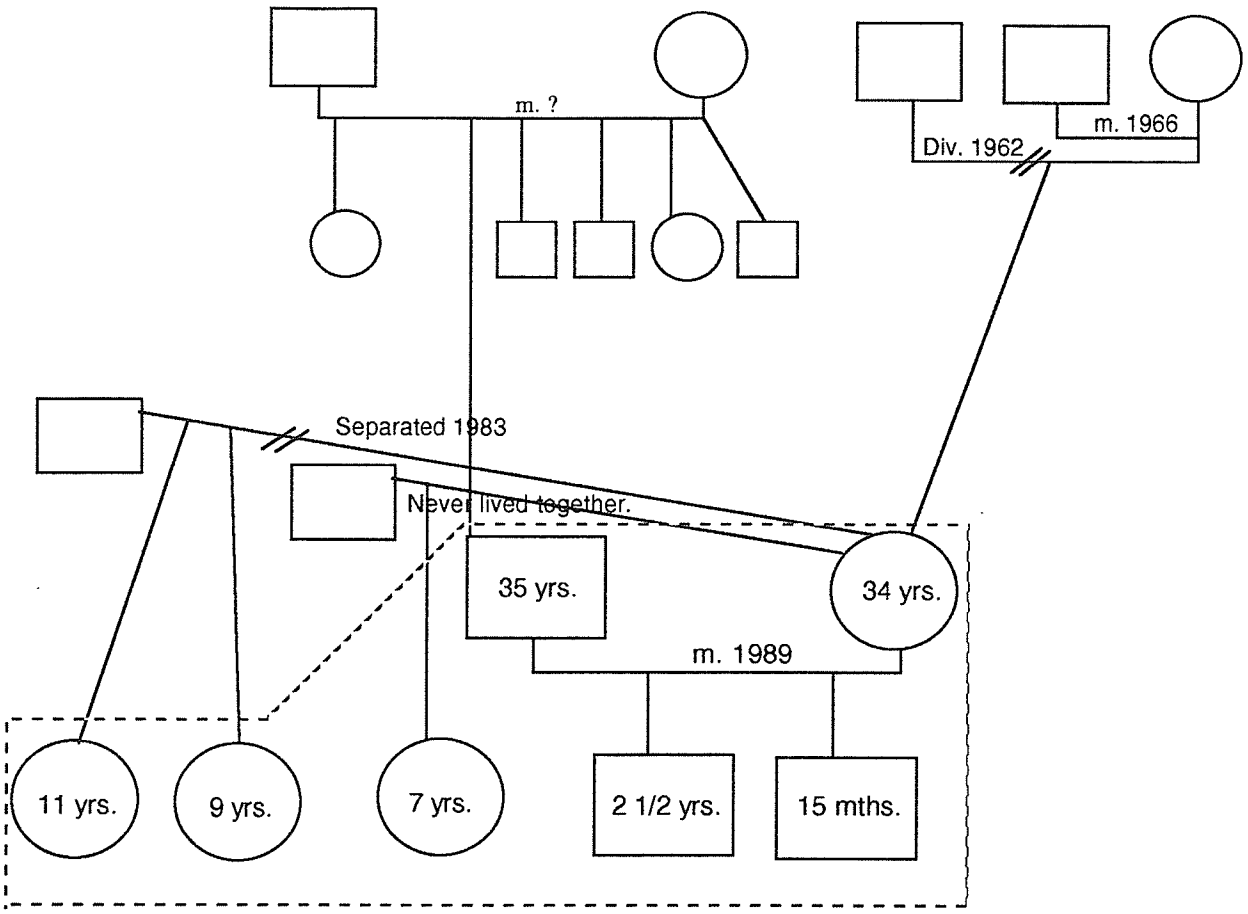

Figure 4. Genogram for Family #1

Table 2

Family #1: Overview of Treatment Plan

Weeks	Sessions	Treatment Plans & Disruptions	Data Collection
1-3	1-3	Interview & assessment.	Pretest data collected
4	4	Feedback session. Homework assignment for parents targeted at increasing time spent together.	
6	5	Attended by parents. Marriage counselling.	
7	6	Attended by 3 oldest children. Intervention targeted at enhancing their relationships with each other.	
9	7	Attended by parents. Mediation of a conflict. Marriage counselling.	
10	8	Attended by parents and 3 oldest children. Family sculpting.	Posttest data collected.
12	9	Termination session. Held at the family's home. Recommended further marriage counselling. Transferred to new co-therapy team. [A member of the father's family died.]	
20-21	10-11	Marriage counselling.	
22		[The mother has surgery and is bedridden for a while.]	
23-24			Follow-up data collected.
25	12	Marriage counselling.	
26	13	Marriage counselling. [The father lost his job.]	
27-29	14-16	Marriage counselling.	
30	17	Termination session. [The father has obtained seasonal employment that will take him out of town for the summer.]	

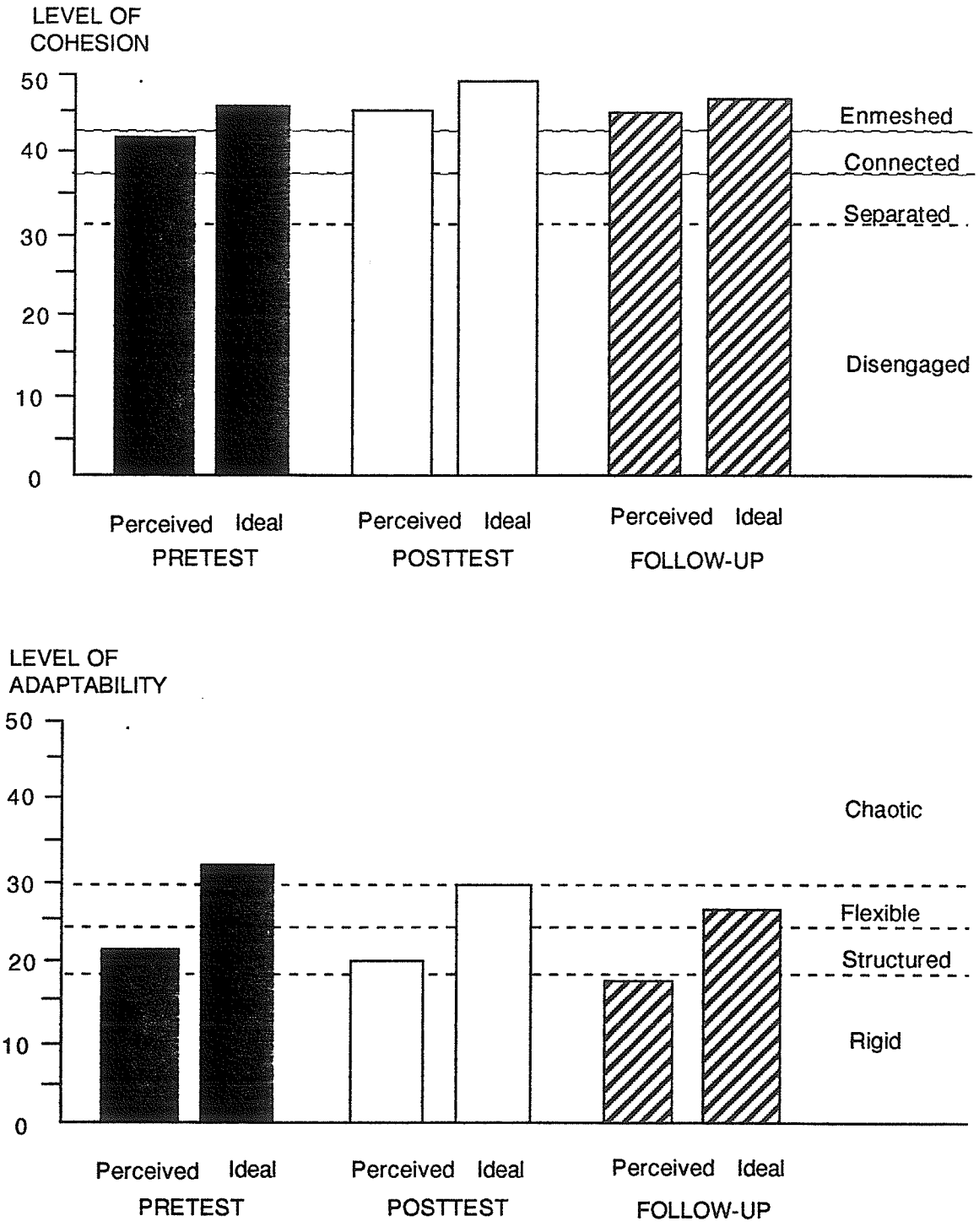

Figure 5. Family Adaptability and Cohesion Evaluation Scale: Family #1--Mother

Table 3

Family Environment Scale: Family # 1--Mother

(Standard Scores)

Scales	Pretest	Posttest	Follow-up
Relationship Dimensions:			
Cohesion	60	60	60
Expressiveness	47	54	66
Conflict	43	43	43
Personal Growth Dimensions:			
Independence	53	53	62
Achievement Orientation	53	60	60
Intellectual-Cultural Orientation	46	58	58
Active-Recreational Orientation	43	48	48
Moral-Religious Emphasis	67	67	62
System Maintenance Dimension:			
Organization	64	64	70
Control	37	54	48

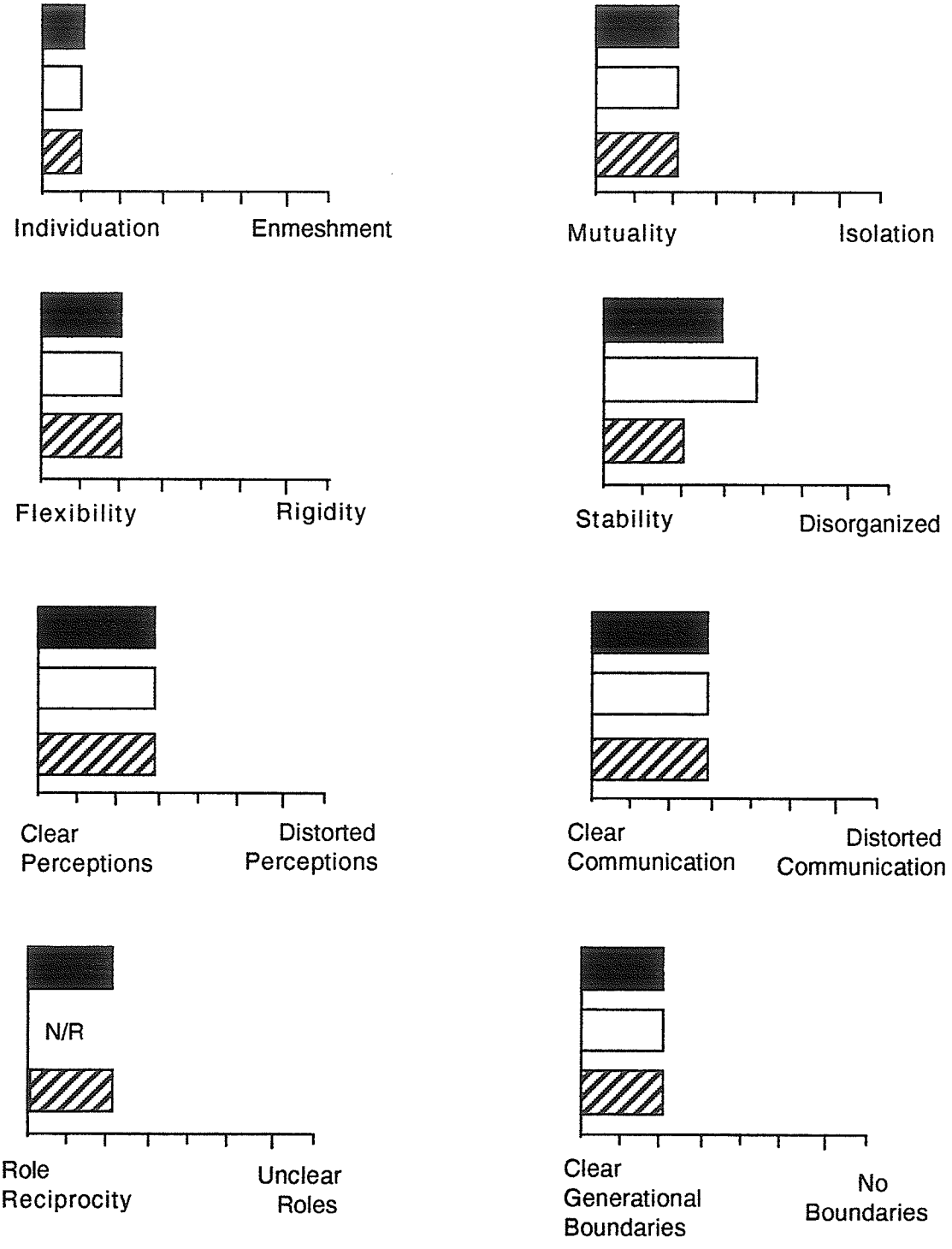

Figure 6. Family Characteristics Scale: Family #1--Mother

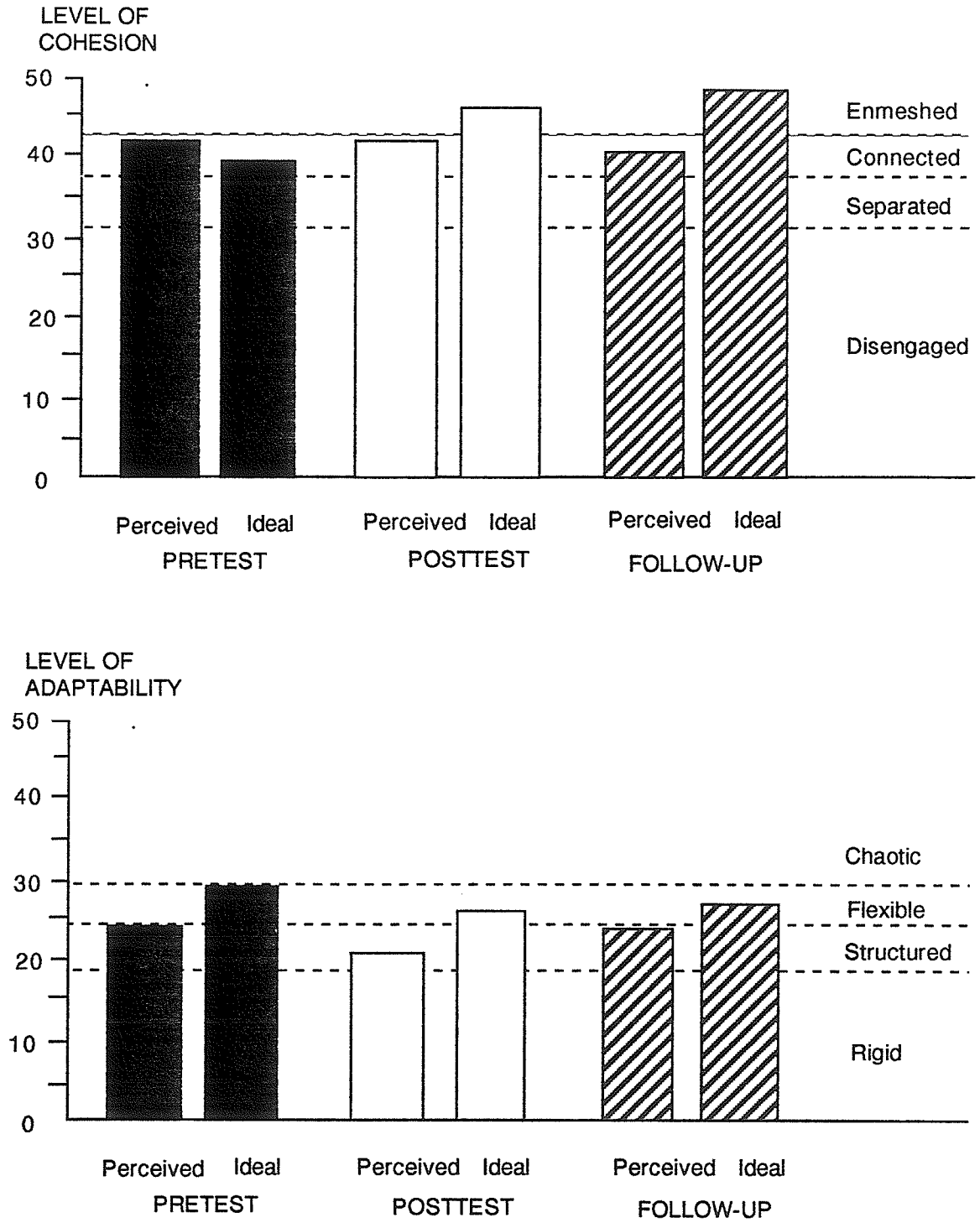

Figure 7. Family Adaptability and Cohesion Evaluation Scale: Family #1--Father

Table 4

Family Environment Scale: Family # 1--Father

(Standard Scores)

Scales	Pretest	Posttest	Follow-up
Relationship Dimensions:			
Cohesion	60	60	68
Expressiveness	60	60	60
Conflict	43	54	54
Personal Growth Dimensions:			
Independence	53	53	53
Achievement Orientation	47	66	53
Intellectual-Cultural Orientation	58	64	64
Active-Recreational Orientation	48	64	59
Moral-Religious Emphasis	72	72	67
System Maintenance Dimension:			
Organization	59	42	70
Control	43	54	43

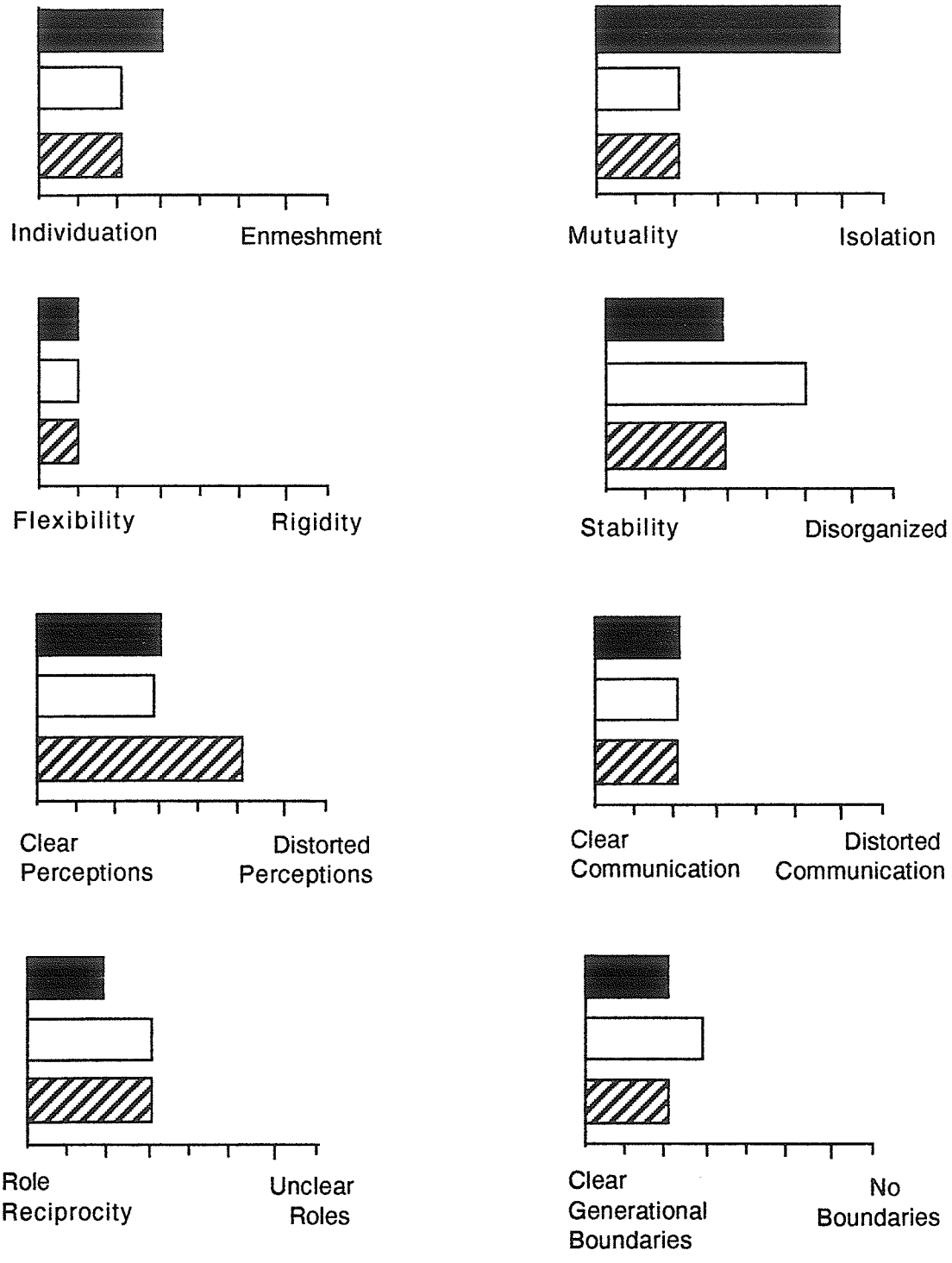

Figure 8. Family Characteristics Scale: Family #1--Father

Table 5

Brief Symptom Inventory: Family #1--Mother

(T Scores)

Global Indices	Pretest	Posttest	Follow-up
Global Severity Index	35	30	42
Positive Symptom Distress Index	36	32	22
Positive Symptom Total	34	31	25

Table 6

Brief Symptom Inventory: Family #1--Father

(T Scores)

Global Indices	Pretest	Posttest	Follow-up
Global Severity Index	32	31	44
Positive Symptom Distress Index	32	31	31
Positive Symptom Total	40	30	34

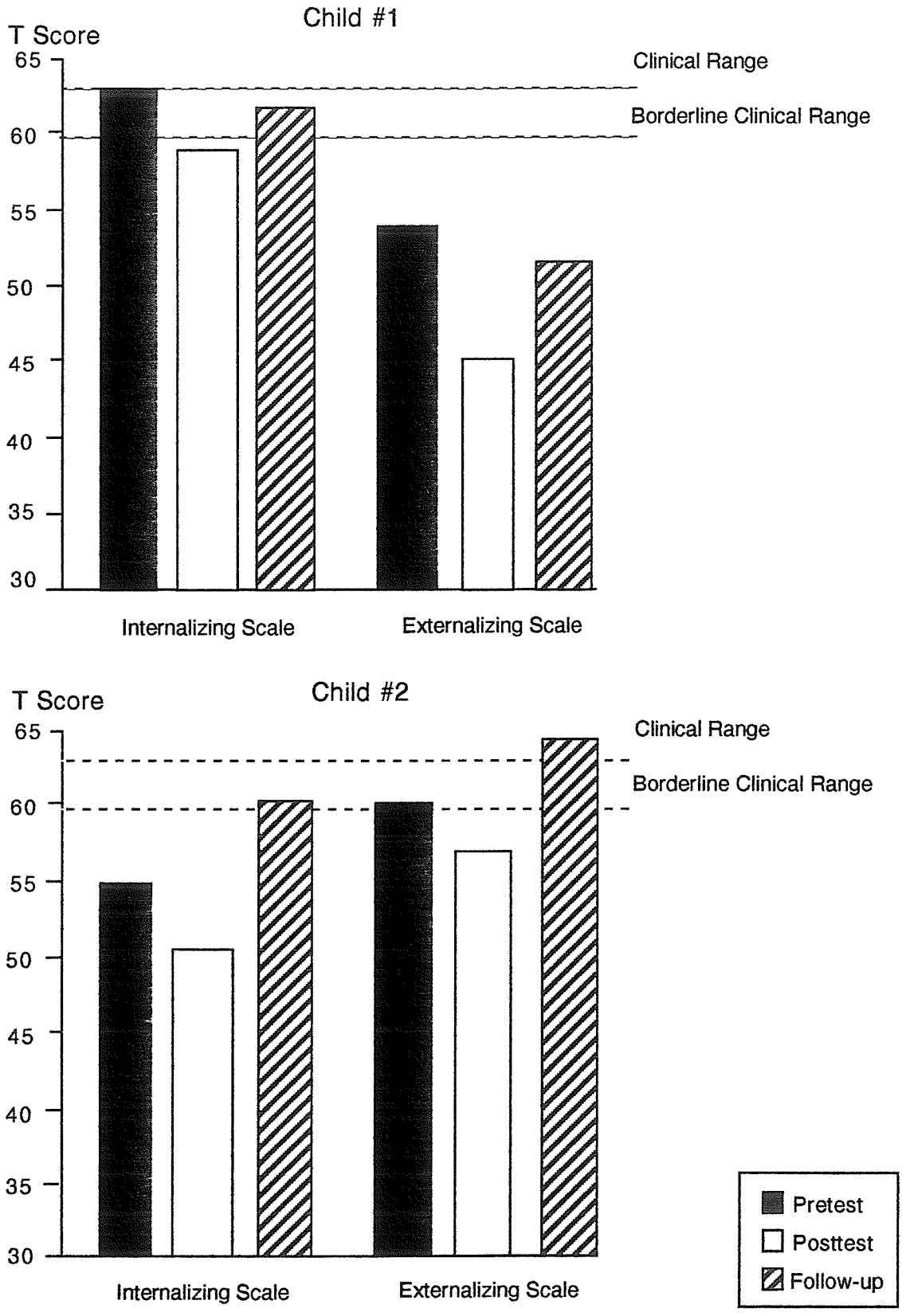

Figure 9a. Child Behavior Checklist: Family #1--Mother

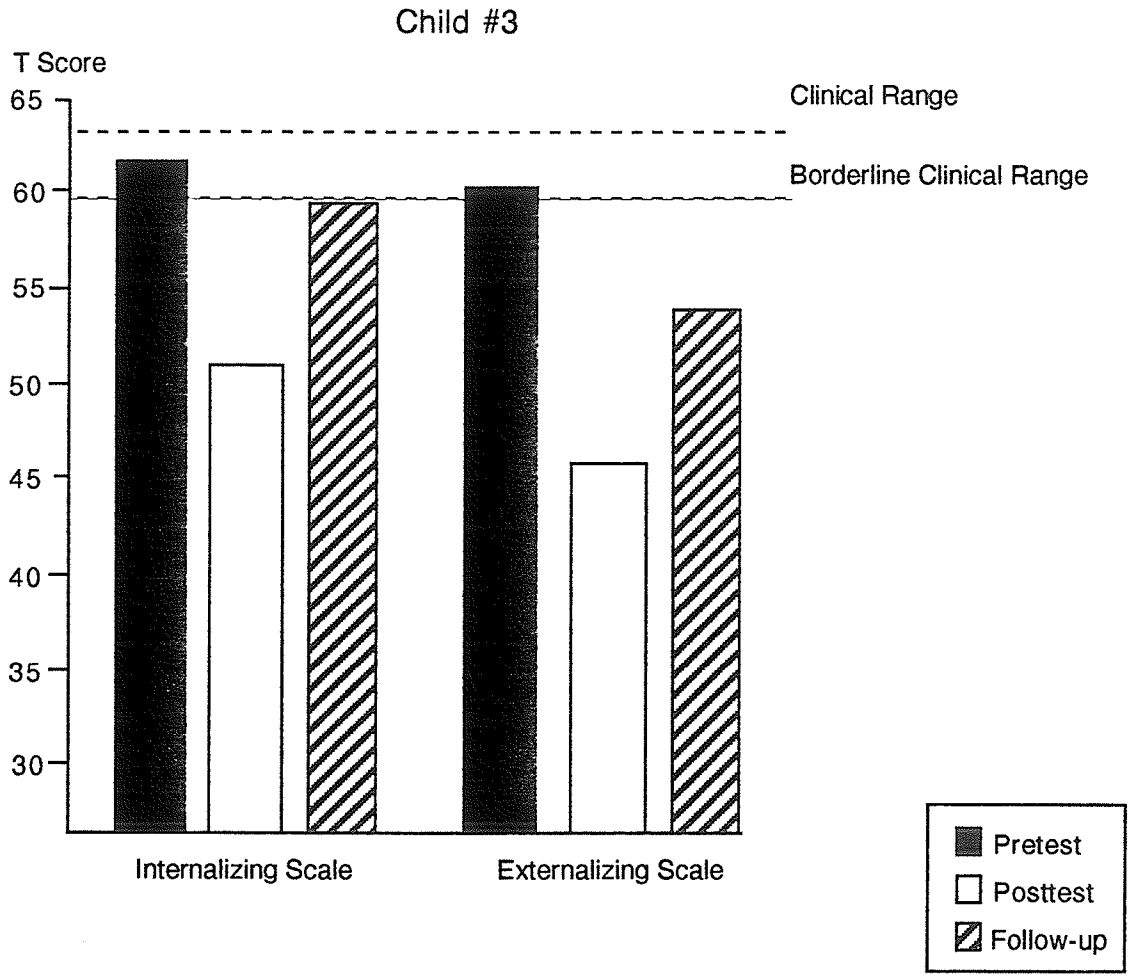

Figure 9b. Child Behavior Checklist: Family #1--Mother

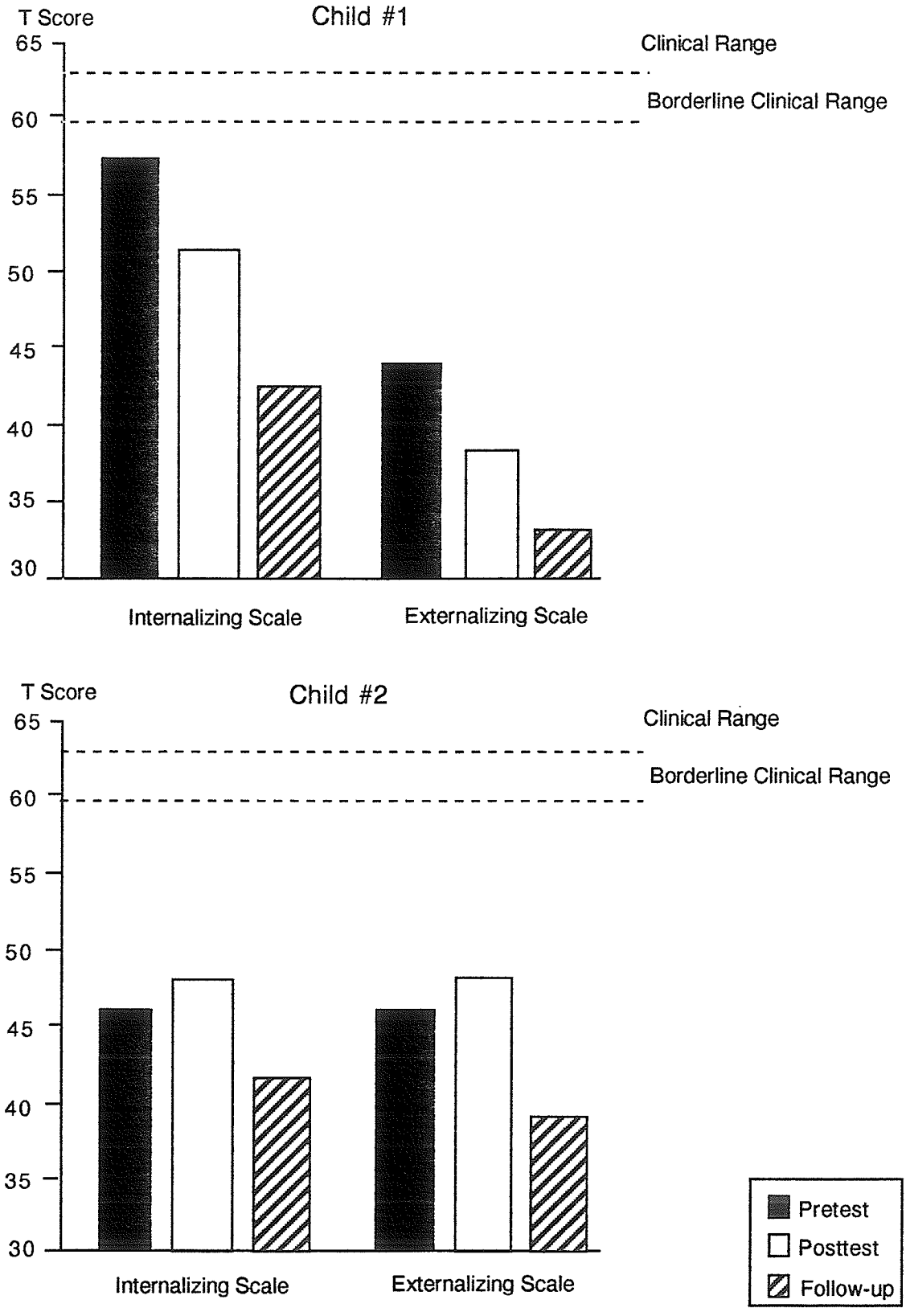

Figure 10a. Child Behavior Checklist: Family #1--Father

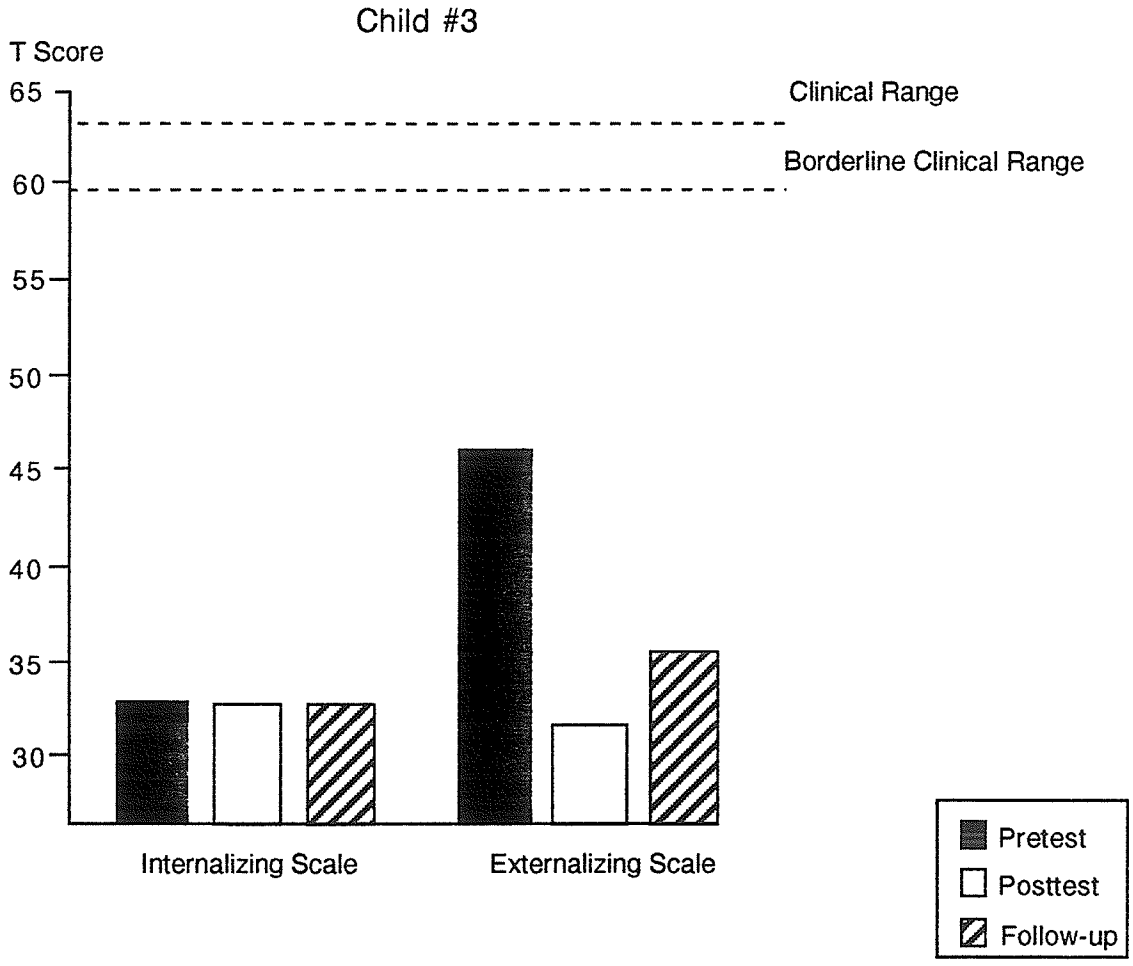

Figure 10b. Child Behavior Checklist: Family #1--Father

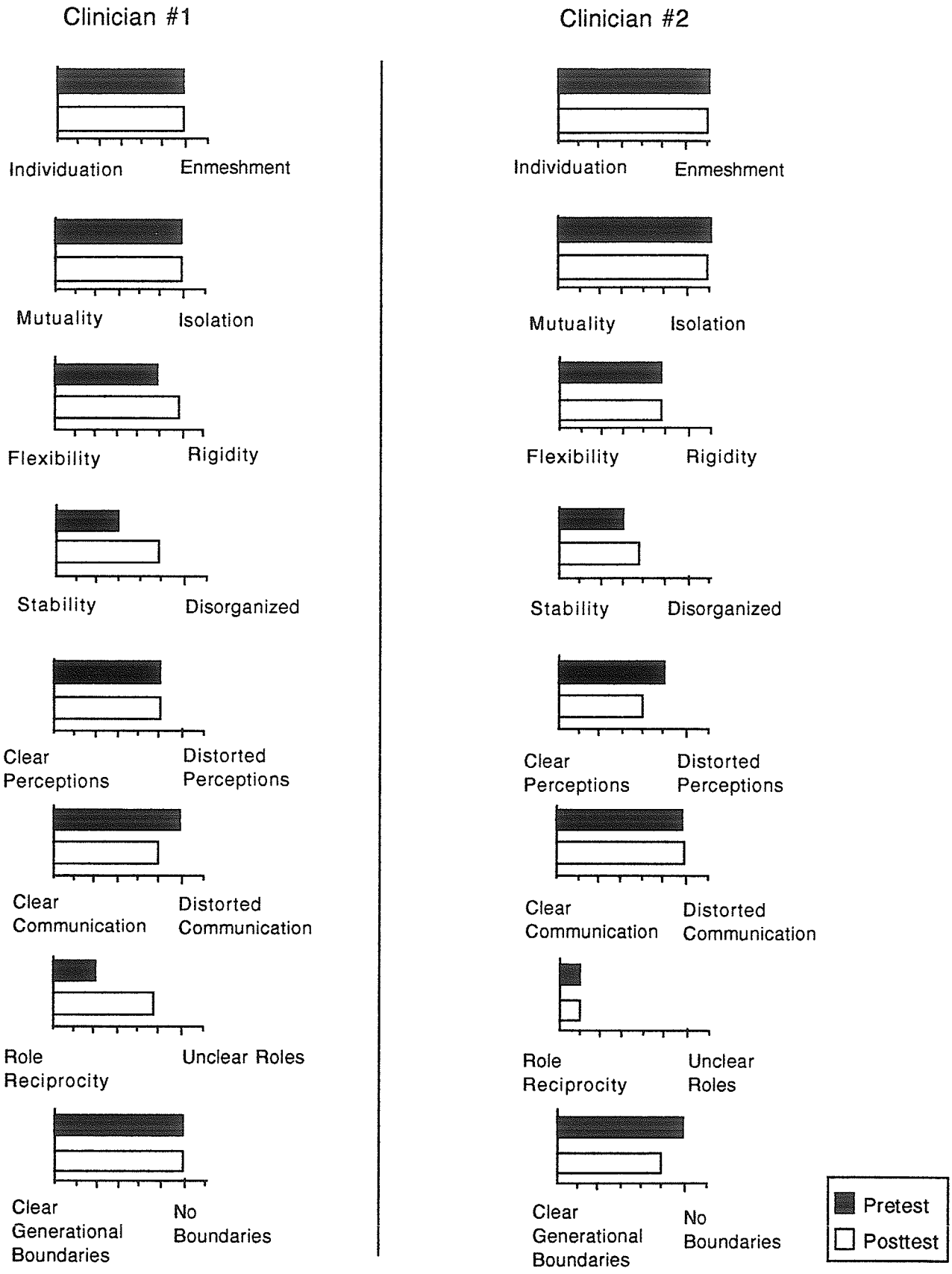

Figure 11. Family Characteristics Scale: Clinicians' Assessment of Family #1

Family #2

Description

This was a two-parent family with two daughters (aged 15 and 17). The parents had been married for 21 years. The family presented as highly articulate and comfortable with the therapeutic process. (A genogram appears in Figure 12, p. 93.)

Presenting Problem

The presenting problem was a high level of conflict within the family. Family members had quite different perceptions of the cause of the conflict. The father attributed the conflict to the older daughter's rebellious behaviour, while the mother attributed it to inconsistent parenting. The older daughter indicated that her father was too authoritarian, and her mother was too intrusive in her life. The younger daughter stated that the family's problems stemmed from her mother's depression and unpredictable moods, and her father's lack of attentiveness to the family. There was also a high level of conflict between the daughters.

Description of Traumatic Experiences

The family had experienced several traumatic events over the 21 years the parents were married. They had a conflictual and stressful relationships with the paternal grandparents, who the mother felt were over-involved in the family's life.

Over the previous five years the family experienced a series of traumatic events. The mother experienced many loses, including the death of two close family members, and the loss of her business. She was

hospitalized twice for depression. Her absence from the home was particularly difficult for her youngest daughter.

Two events that were particularly traumatic for the family were the oldest daughter's running away, and the youngest daughter's suicide attempt. The former event occurred about two years before the family began therapy. The daughter ran away with her boyfriend, and she was arrested and charged with theft and fraud. The suicide attempt of the youngest daughter occurred just two months before the family began family therapy.

The mother also experienced trauma in her childhood. At the age of six, she witnessed her father die of a heart attack.

Formulation

The functioning of this family was problematic on several dimensions. The enmeshment and isolation of family members interfered with the development of a strong parental/marital subsystem and clear generational boundaries. As a result, the family had been unable to accomplish the major life cycle task required of families with adolescent children, which is to establish permeable boundaries to allow adolescents to move in and out of the family system (Carter and McGoldrick, 1989). Family members had acquired or assumed roles that had contributed to the maintenance of the family system. The older daughter was the "scapegoat", and the younger daughter was the "good child". The parents had difficulty fulfilling their role as executive heads of the family. They experienced problems establishing and enforcing rules, delegating responsibilities, and supporting and nurturing their children.

The area of family functioning targeted for intervention was generational boundaries. This was based on the hypothesis that this

dimension was a major influence in the dysfunction of individual family members, especially the children's behaviour problems and the emotional problems of the younger daughter. It was also assessed that generational boundaries was the area of family functioning that would be most malleable and amenable to intervention because the symptoms were generally consistent with family members' own perceptions of their problems: the over-involvement of the father and the older daughter, the alliance of the mother and the youngest daughter, and the parents' ineffectiveness in fulfilling their executive role.

Course of Treatment

Following three assessment sessions, the family was seen for five treatment sessions, a review session, and a further four treatment sessions. The focus of treatment was to reinforce the generational boundaries. The treatment plan involved strengthening the marital/parental and sibling subsystems, and strengthening the boundaries between the subsystems. An overview of the treatment plan is in Table 7 (p. 94).

The children attended only one treatment session. The family had been in family therapy before coming to this program, and the younger daughter was attending group therapy. The children lacked motivation for further family therapy. The parents continued treatment without them.

Several interventions were used to strengthen the generational boundaries. One intervention was to discuss the different roles family members had assumed or been assigned, and the impact of the roles on each individual and on the family system. The role of the older daughter was the scapegoat, and the role of the younger daughter was the good child. The mother indicated that this discussion had confirmed her belief that the

older daughter was the scapegoat. In later sessions she reported less conflict and an enhanced relationship with her older daughter.

Another intervention to strengthen generational boundaries was to assist the parents to establish rules and consequences for noncompliance with the rules. The parents discovered that they had a different understanding of the rules. Once they reached an agreement on what the rules should be, they realized that, with few exceptions, the children generally complied with the rules. The parents also seemed to increase their understanding of the impact of their inconsistency in enforcing the rules. However, attempts by the parents to increase their consistency in enforcing the rules were generally unsuccessful. The mother frequently did not follow through with the consequences that she and her husband had agreed on, and she often interfered with the father's attempts to follow through.

At the second treatment session, which was attended by all family members, the therapists mediated a conflict (Table 7, p. 94, session #6). The conflict related to the family's holiday plans. A short time before they were to leave, the younger daughter told the family she did not wish to go. Intervention focused on enhancing the family's problem-solving skills, and enhancing the parents' executive skills. The family resolved the conflict immediately following the session, and the solution was satisfactory to all family members.

An intervention used to strengthen the marital subsystem was instruction in anger management. Through discussion and exercises, the couple enhanced their understanding of the ineffectiveness and destructiveness of their way of expressing anger. Anger management was

the focus of three additional treatment sessions (Table 7, p. 94, sessions 11 to 13).

Several interventions were used to assist the couple to learn to express their anger more constructively. One intervention was to explore how anger was expressed in their families-of-origin, and their perceptions of each other's way of expressing anger. They were also provided with literature on anger and anger management. The second intervention was to suggest that they each keep a journal of their anger, noting events that triggered their anger, the way they expressed their anger and the outcome. This suggestion was not followed. The third intervention involved instruction in some basic communication skills. It was found that practicing these skills frequently precipitated an argument in the session. There was no evidence that these interventions had an impact on the parents' anger management skills.

Data

Family Functioning: Mother

The findings from the FACES suggest that the mother's perception of the family's level of cohesion decreased substantially from the pretest to the posttest, moving from a moderate level, described as separated, to the low level of the scale, described as disengaged. It remained at a low level in the follow-up data. The mother's conception of an ideal level of cohesion for the family was substantially higher than her perceived level at each measurement point (Figure 13, p. 95).

In contrast, the mother's perception of the family's level of adaptability increased over the course of the study, moving from a moderate level in the pretest and the posttest, to the high end of the scale in the follow-up. At the

same time, her ideal level of family adaptability decreased over the course of the study. There was only a very slight difference between the perceived and ideal levels of adaptability at the time of the follow-up (Figure 13, p. 95).

The findings from the FES suggest that the family's level of cohesion and the independence of family members (i.e., the extent to which family members are assertive and make their own decisions) decreased substantially from the pretest to the posttest, then increased slightly in the follow-up (Table 8, p. 96).

The findings from the Family Characteristics Scale suggest that from the pretest to the posttest, the mother's perceptions of her family's flexibility and ability to cope with change increased. This improvement was sustained in the follow-up. The findings also suggest a substantial deterioration on the dimension of clear versus diffuse generational boundaries from the pretest to the posttest. This improved somewhat in the follow-up. The findings from the follow-up also suggest improvements in the dimension of clear versus distorted perceptions, mutuality versus isolation, and stability versus disorganization (Figure 14, p. 97).

Family Functioning: Father

The findings from the FACES for the father suggest that he perceived the family's level of cohesion and adaptability to increase substantially from the pretest to the posttest. Both dimensions moved from the low end of the scale to a moderate level. This improvement was sustained in the follow-up (Figure 15, p. 98).

The findings from the FES also indicate a substantial increase in the family's level of cohesion. This increase was sustained in the follow-up. A substantial increase was also evident in the subscale measuring

expressiveness (i.e., the extent to which family members are encouraged to act openly and to express their feelings directly). The subscale measuring the independence of family members suggest that family members had become less independent from the pretest to the posttest. This increased slightly in the follow-up. Finally, small but consistent decreases were evident in the level of family conflict over the course of the study (Table 9, p. 99).

The findings from the Family Characteristics Scale suggest improvement in the dimensions of individuation versus enmeshment, and clear versus distorted communication. The dimensions of role reciprocity versus unclear roles, and clear versus diffuse generational boundaries also improved slightly. The improvement in generational boundaries was not sustained in the follow-up. The dimensions of mutuality versus isolation, and flexibility versus rigidity deteriorated from the pretest to the posttest. The latter had returned to baseline level in the follow-up data (Figure 16, p. 100).

Symptomatology: Mother

The findings from the BSI suggest that the mother was experiencing a high level of psychological distress at the time of the pretest, but it decreased substantially over the course of the study (Table 10, p. 101).

The findings from the Trauma Sequelae suggest that the mother was experiencing symptoms consistent with a diagnosis of PTSD in the pretest and the posttest. Her symptoms decreased in the follow-up, but were consistent with a diagnosis of subclinical or partial PTSD (see Appendix H).

Symptomatology: Father

The father's level of psychological distress, as measured by the BSI, was low at each measurement point. However, there was a notable increase in the global severity index from the pretest to the posttest (Table 11, p. 102).

The findings from the Trauma Sequelae were not suggestive of symptoms of PTSD.

Symptomatology: Children

The CBCL and the CSBI were completed separately by the mother and the father for each daughter. The girls each completed the CBCL-Youth Self Report.

The findings from the CBCL suggest that the mother perceived the internalizing and externalizing behaviours of the older child to decrease consistently over the course of the study. In regard to the younger child, the mother perceived both internalizing and externalizing behaviours to increase slightly from the pretest to the posttest, then to decrease substantially in the follow-up (Figure 17, p. 103).

The father perceived the internalizing and externalizing behaviours of the older child to decrease in the posttest, then to increase substantially in the follow-up. In the follow-up, he rated this daughter's behaviour the highest rating possible on almost every item in the scales. Similar to the trend noted in the findings for the mother, the father perceived the internalizing and externalizing behaviours of the younger child to increase from the pretest to the posttest, then to decrease substantially in the follow-up (Figure 18, p. 104).

The findings for the CSBI, completed separately by the parents for both children, are not suggestive of any problematic sexual behaviours.

The findings from the CBCL-Youth Self Report, completed by the older child suggest that in the pretest, she perceived her internalizing and externalizing behaviours to be in the clinical range. Her scores on the internalizing and externalizing scales decreased from the pretest to the posttest, and her score on the externalizing scale decreased further in the follow-up. In the follow-up, her scores did not fall in the clinical range for either internalizing or externalizing behaviours (Figure 19, p. 105).

The findings from the CBCL-Youth Self Report, completed by the younger child, suggest that she perceived herself to be in the clinical range on both internalizing and externalizing behaviours at each of the three measurements. These behaviours increased consistently over the course of the study (Figure 20, p. 106). This suggests that she perceived her internalizing and externalizing behaviours to be much more problematic than did her parents, particularly her father, who rated these behaviours at a relatively low level in the follow-up.

Client Satisfaction

The findings from the client satisfaction questionnaire indicate that both parents were very satisfied with the services they received, and that they would definitely use the services again.

Clinicians' Impressions of the Outcome of Treatment

Treatment was judged to be somewhat successful by the two clinicians who treated the family. They believed that some progress was made in strengthening generational boundaries and the marital/parental

subsystem. The goal of strengthening the sibling subsystem was not achieved because the girls chose not to participate in treatment after the first treatment session.

In regard to generational boundaries, the level of conflict between the mother and the older daughter decreased, both children generally followed the rules, and the mother said that she was generally satisfied with the children's behaviour since treatment began. The father disagreed with the mother's assessment in the older daughter's behaviour. He continued to complain about her noncompliance with the rules and irresponsible behaviour.

In regard to the marital/parental subsystem, there seemed to be an increase in the degree of openness and expressiveness between the parents, and they seemed to be more effective in carrying out their executive functions.

The data from the Family Characteristics Scale that was completed separately by each clinician in the pretest and posttest, suggest that both clinicians perceived some improvement on the dimension of clear versus diffuse generational boundaries. In addition, clinician #1 perceived improvement on the dimension of individuation versus enmeshment, and clinician #2 perceived improvement on the dimensions of mutuality versus isolation, clear versus distorted perceptions, and clear versus distorted communication (Figure 21, p. 107).

Summary of Family #2

The presenting problem of this family was a high level of conflict within the family, particularly between the older daughter and the parents. The older daughter was the scapegoat for the family's problems. There was

an enmeshed relationship between the younger daughter and the mother, and she had the role of "good child". Family members were emotionally isolated from each other. The parents were unable to fulfill their executive function, and the mother often sabotaged the father's efforts to enforce the rules.

The area of family functioning targeted for intervention was generational boundaries. The treatment plan focused on strengthening the marital/parental and sibling subsystems. Treatment was judged by the clinicians to be somewhat successful, but the gains were relatively small.

Progress was made in strengthening the generational boundaries. The mother reported a decrease in the level of conflict between her and her older daughter. She also reported that both girls were generally complying with the rules. Some progress was also achieved in strengthening the marital/parental subsystem. The couple seemed more open with each other, and their ability to discuss and negotiate ways of handling problem situations relating to their children seemed to be enhanced. However, the mother continued to have difficulty enforcing the rules. The parents modified the rules to accommodate the children's growing need for independence, but the father continued to feel that the rules were not strict enough.

The goal of strengthening the sibling subsystem was largely not achieved, primarily because the girls chose not to participate in treatment.

The data from the self-report measures on family functioning suggest that the mother and father had different perceptions of several of the variables measured. Most notably, the mother perceived that family cohesion, measured by the FACES and the FES, to decrease over the course of the study. In contrast, the father's response to these measures suggest that he perceived family cohesion to increase. The findings from the

FACES suggest that the mother's ideal level of cohesion was significantly higher than the father's. The decrease in the level of cohesion perceived by the mother might reflect the increasing individuation of the children, which the mother might view as a decrease in the emotional connectedness of family members.

The findings from the FES suggest that the father perceived improvements in expressiveness. The findings from the Family Characteristics Scale suggeste that he perceived improvement in communication patterns, role reciprocity, and the clarity of generational boundaries. This might reflect his increased satisfaction with the marital relationship. The mother's findings relating to these variables remained relatively constant over the course of the study. The data from the FES indicate that the mother perceived the level of conflict in the family to decrease substantially over the course of the study. Both parents perceived that the family's level of adaptability, as measured by the FACES to increase.

The findings from the self-report measures of psychological distress and PTSD suggest that the mother had a high level of psychological distress at the beginning of treatment and symptoms that are consistent with a diagnosis of PTSD. Her level of psychological distress decreased significantly over the course of the study, and her symptoms of PTSD decreased in the follow-up. These findings probably reflect, to a large extent, her use of anti-depressant medication, which began about half-way through treatment.

The results of the CBCL suggest that the parents' perceptions of their children's behaviour is somewhat different than that of the children. The mother's perception of the older daughter's internalizing and externalizing

behaviour is consistent with the older daughter's perception. They perceived her behaviour to improve over the course of the study. However, the father's results suggest that he perceived her behaviour to have deteriorated significantly at the time of the follow-up. This is consistent with the daughter's role as the scapegoat. In regard to the younger daughter, both parents indicated that her behaviour deteriorated in the posttest, then improved in the follow-up. In contrast, she indicated that her behaviour deteriorated consistently over the course of the study. Her results suggest that her internalizing and externalizing behaviours were in the clinical range at each measurement point.

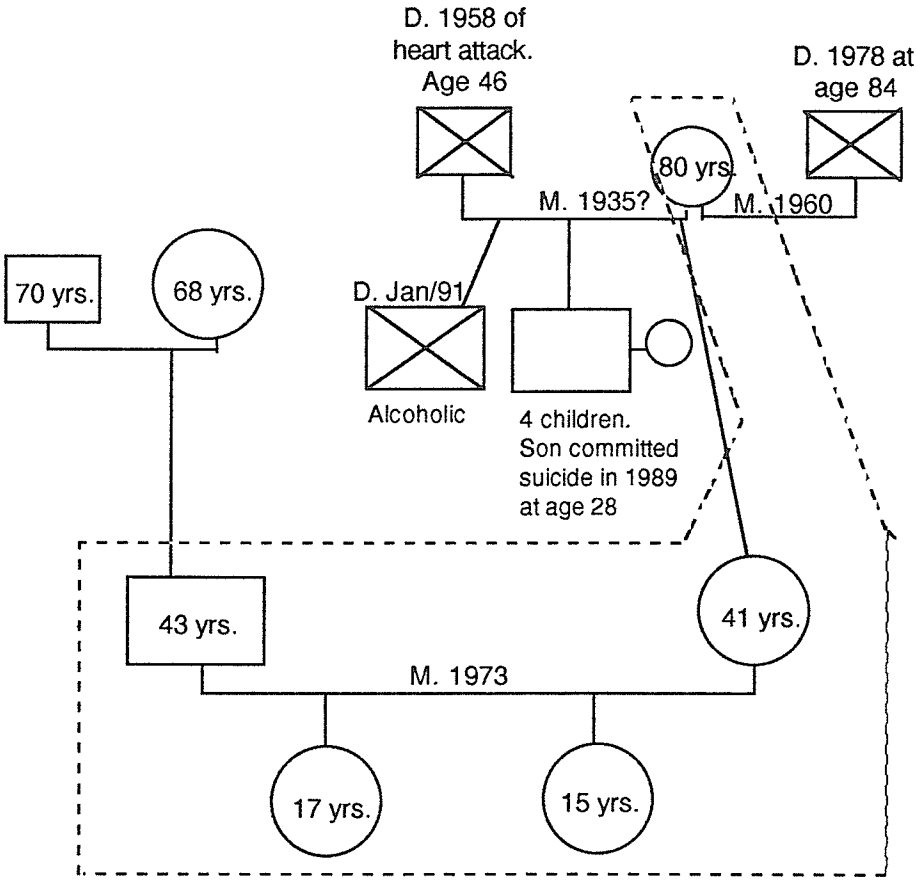

Figure 12. Genogram for Family #2.

Table 7

Family #2: Overview of Treatment Plan

Weeks	Sessions	Treatment Plans & Disruptions	Data Collection
1-3	1-3	Interview & assessment	Pretest data collected
4	4	Feedback session.	
5	5	Attended by parents. Parent training.	
6	6	Attended by all family members. Mediation of a conflict.	
11-13	7-9	Attended by parents. Parent training & anger management. [Children chose to discontinue therapy after session #6. Younger daughter also discontinued group therapy. Mother began taking anti-depressant medication.]	
14	10	Termination session. Recommended further therapy focusing on anger management and parent training.	Posttest data collected.
17-19	11-13	Anger management, communication skills & parent training.	
20	14	Termination session.	
23			Follow-up data collected.

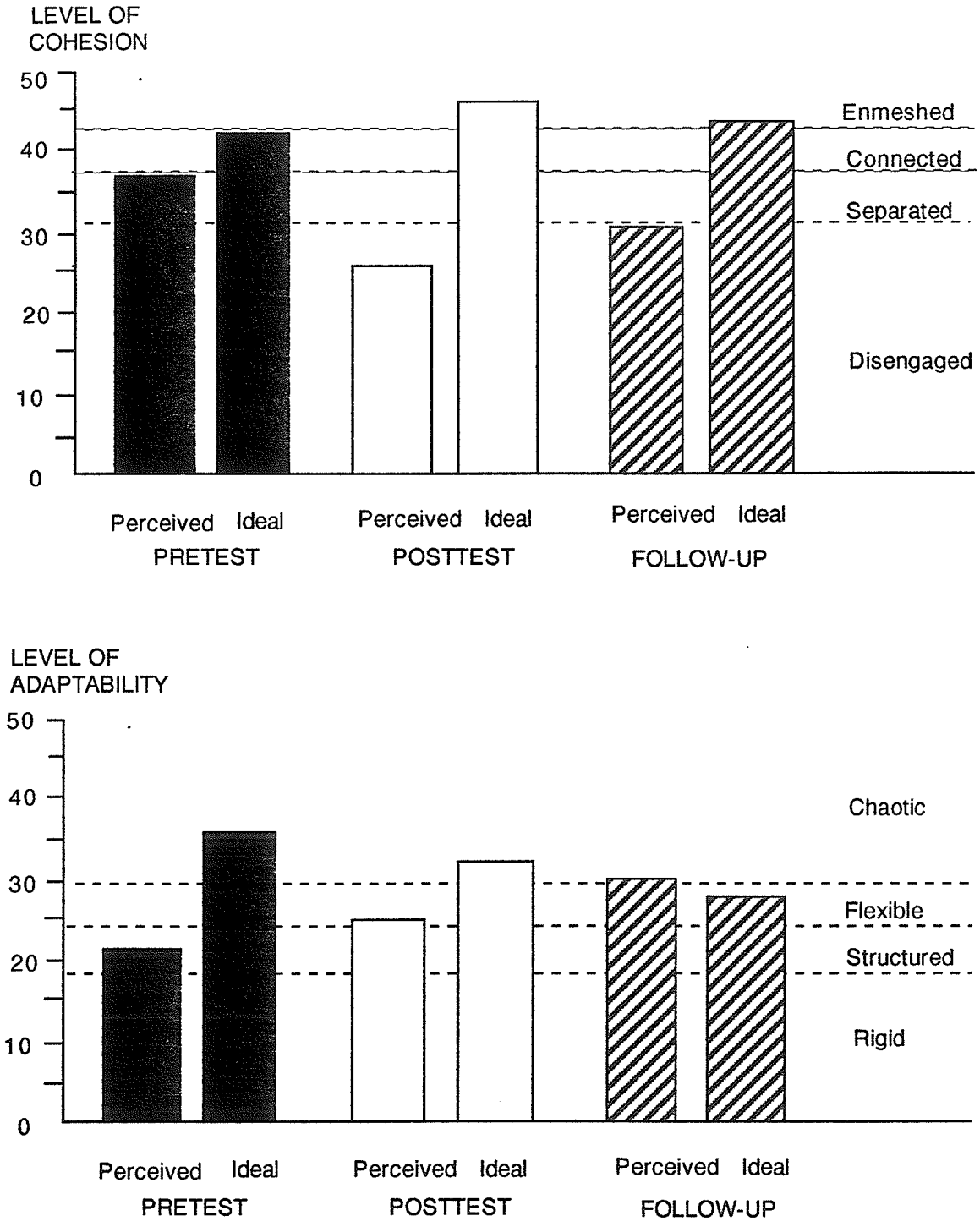

Figure 13. Family Adaptability and Cohesion Evaluation Scale: Family #2--Mother

Table 8

Family Environment Scale: Family # 2--Mother

(Standard Scores)

Scales	Pretest	Posttest	Follow-up
Relationship Dimensions:			
Cohesion	53	38	46
Expressiveness	60	66	66
Conflict	70	65	54
Personal Growth Dimensions:			
Independence	62	45	53
Achievement Orientation	35	28	28
Intellectual-Cultural Orientation	23	29	35
Active-Recreational Orientation	32	37	37
Moral-Religious Emphasis	36	31	41
System Maintenance Dimension:			
Organization	48	53	53
Control	37	43	43

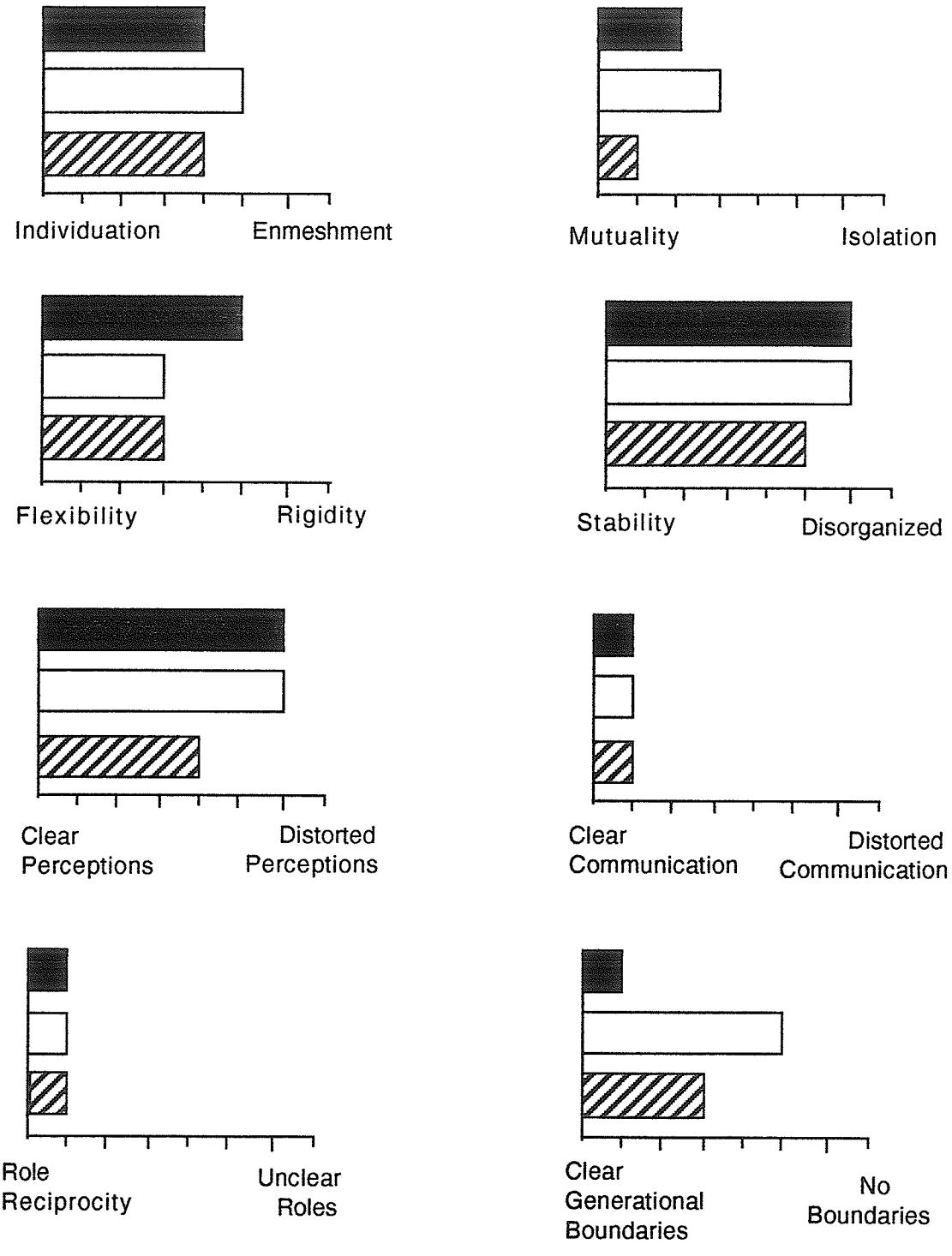

Figure 14. Family Characteristics Scale: Family #2--Mother

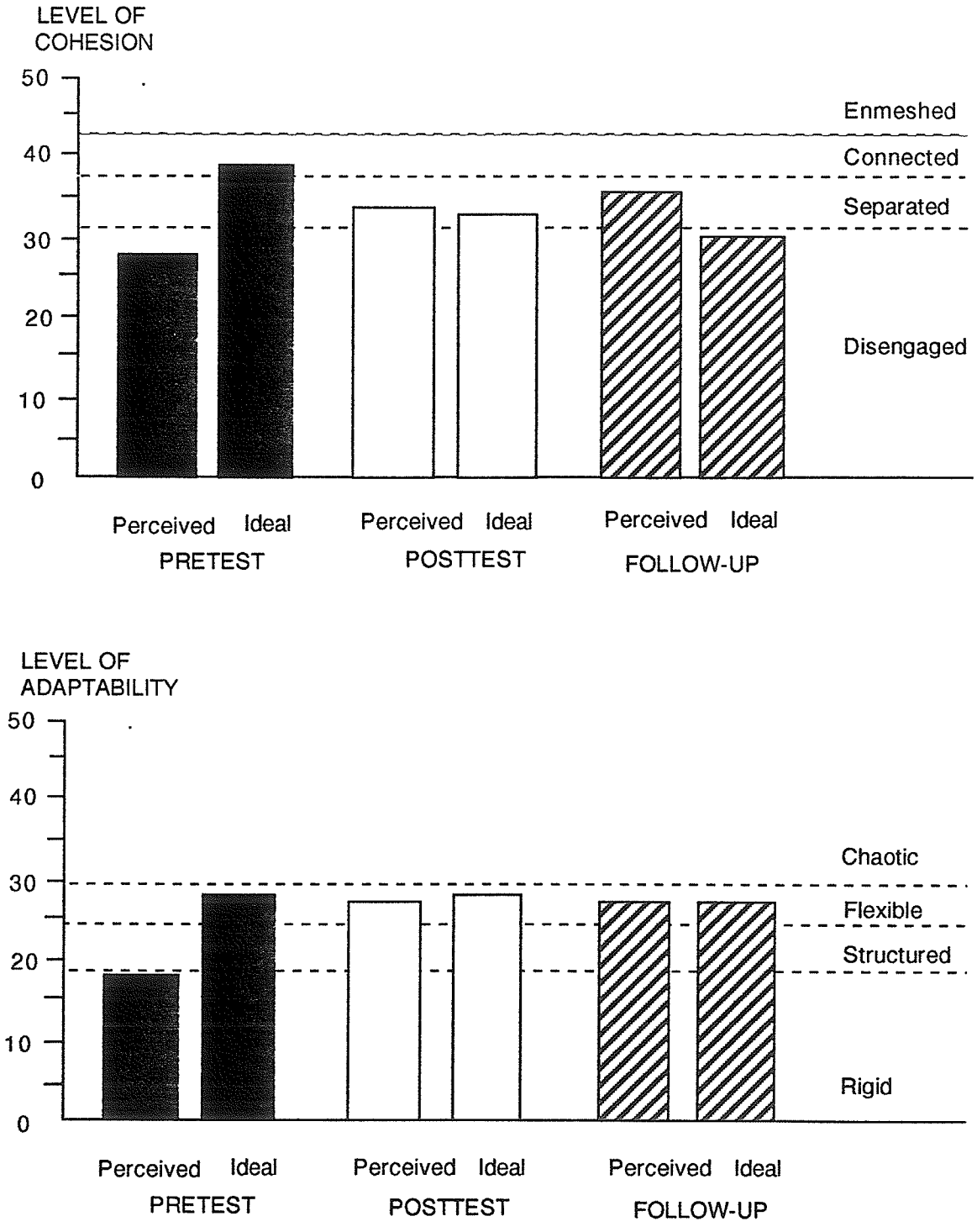

Figure 15. Family Adaptability and Cohesion Evaluation Scale: Family #2--Father

Table 9

Family Environment Scale: Family # 2--Father

(Standard Scores)

Scales	Pretest	Posttest	Follow-up
Relationship Dimensions:			
Cohesion	23	53	53
Expressiveness	28	47	60
Conflict	59	54	48
Personal Growth Dimensions:			
Independence	53	36	45
Achievement Orientation	41	45	41
Intellectual-Cultural Orientation	35	29	23
Active-Recreational Orientation	43	48	48
Moral-Religious Emphasis	41	41	36
System Maintenance Dimension:			
Organization	53	59	59
Control	54	59	32

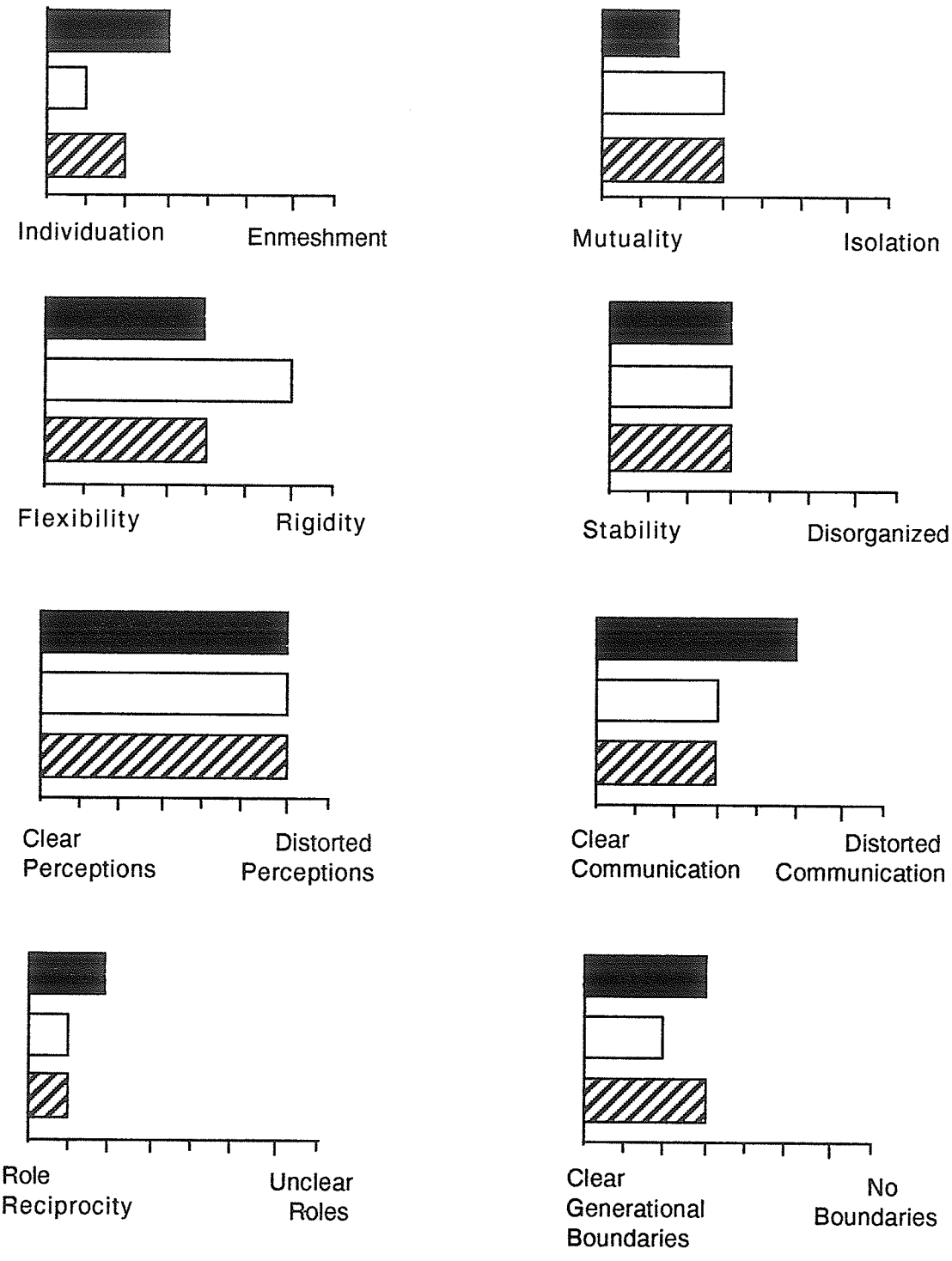

Figure 16. Family Characteristics Scale: Family #2--Father

Table 10

Brief Symptom Inventory: Family #2--Mother

(T Scores)

Global Indices	Pretest	Posttest	Follow-up
Global Severity Index	76	57	42
Positive Symptom Distress Index	78	53	40
Positive Symptom Total	69	58	45

Table 11

Brief Symptom Inventory: Family #2--Father

(T Scores)

Global Indices	Pretest	Posttest	Follow-up
Global Severity Index	0	39	29
Positive Symptom Distress Index	0	29	29
Positive Symptom Total	0	29	30

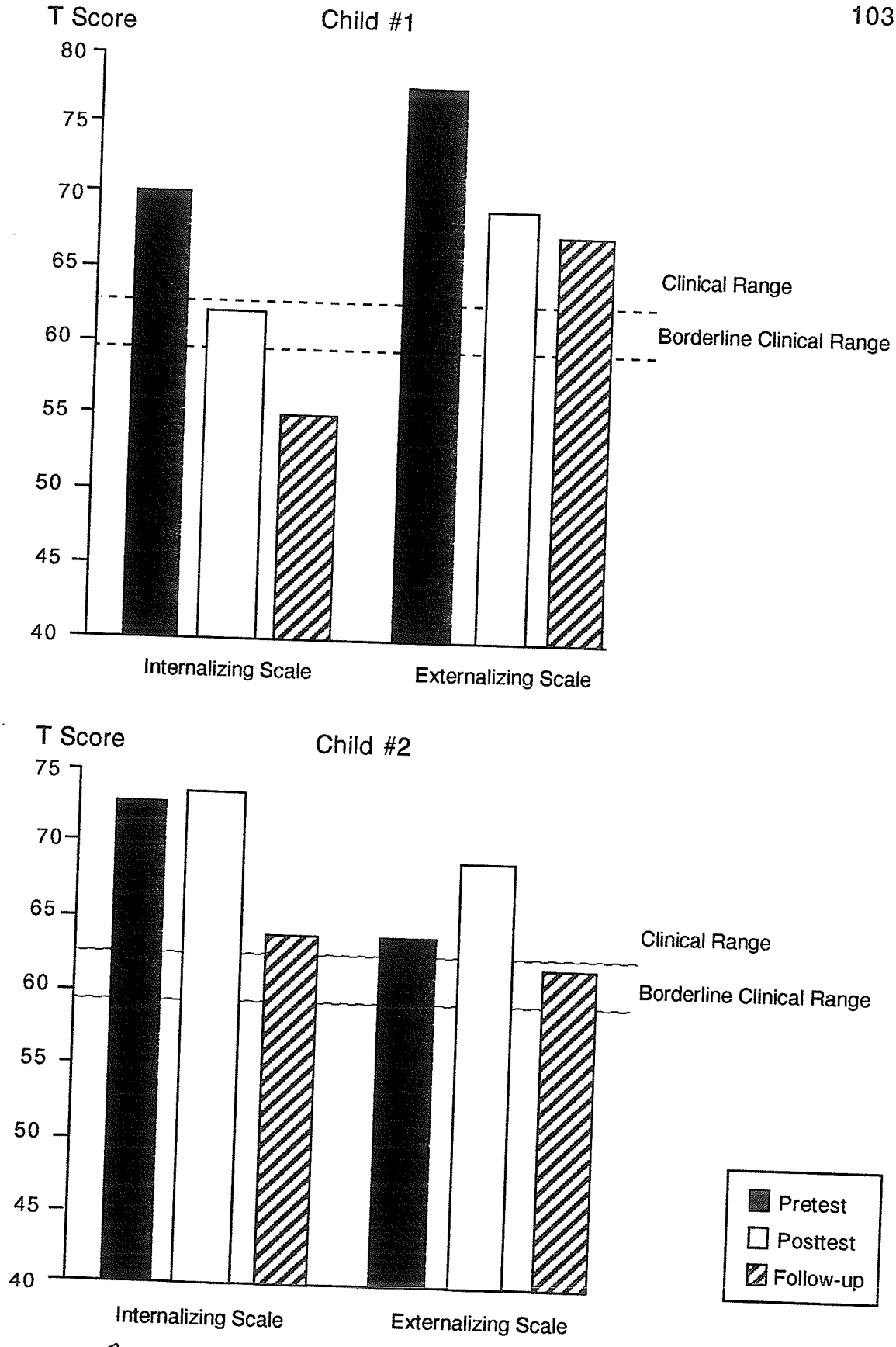

Figure 16. Child Behavior Checklist: Family #2--Mother

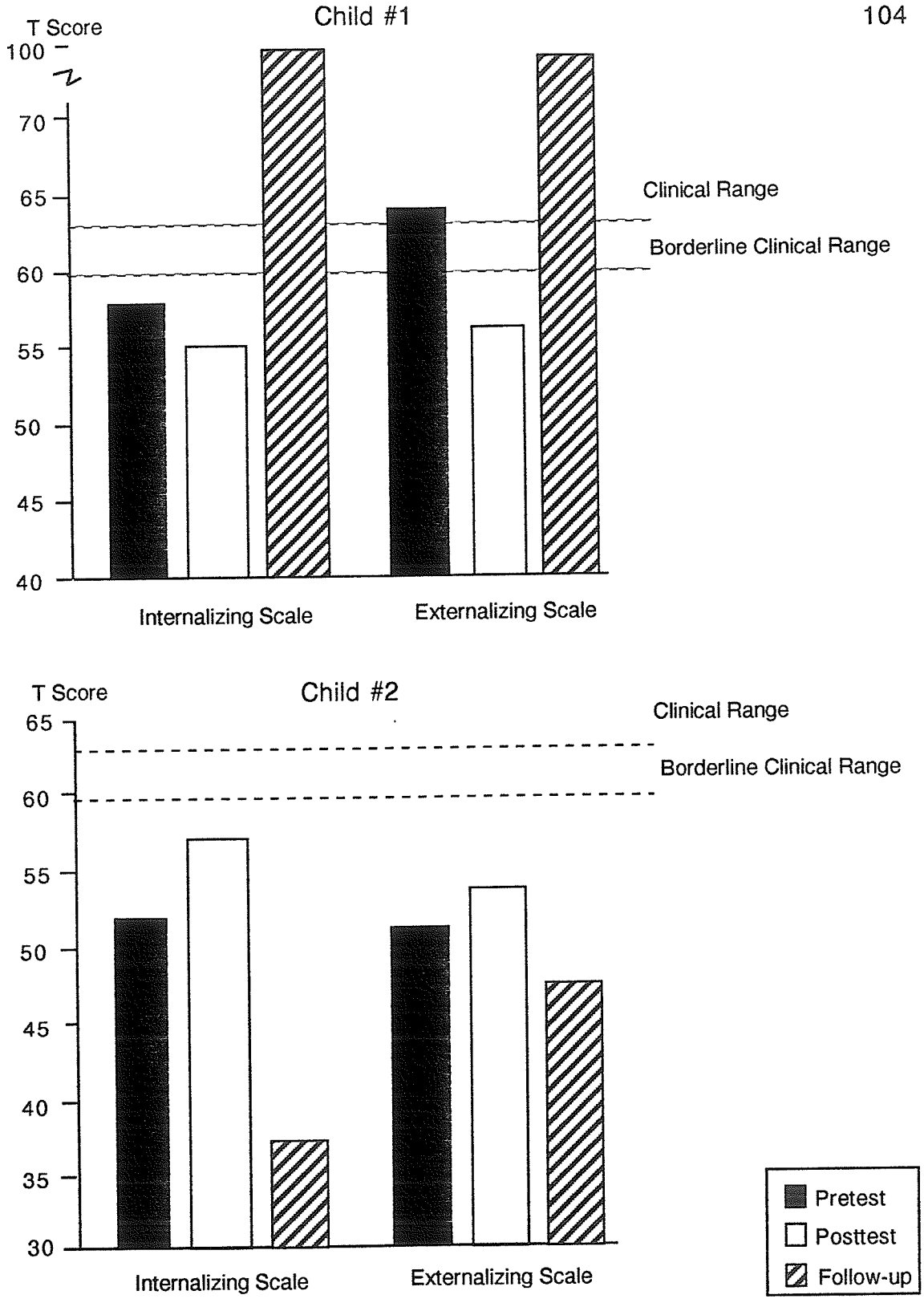

Figure 18. Child Behavior Checklist: Family #2--Father

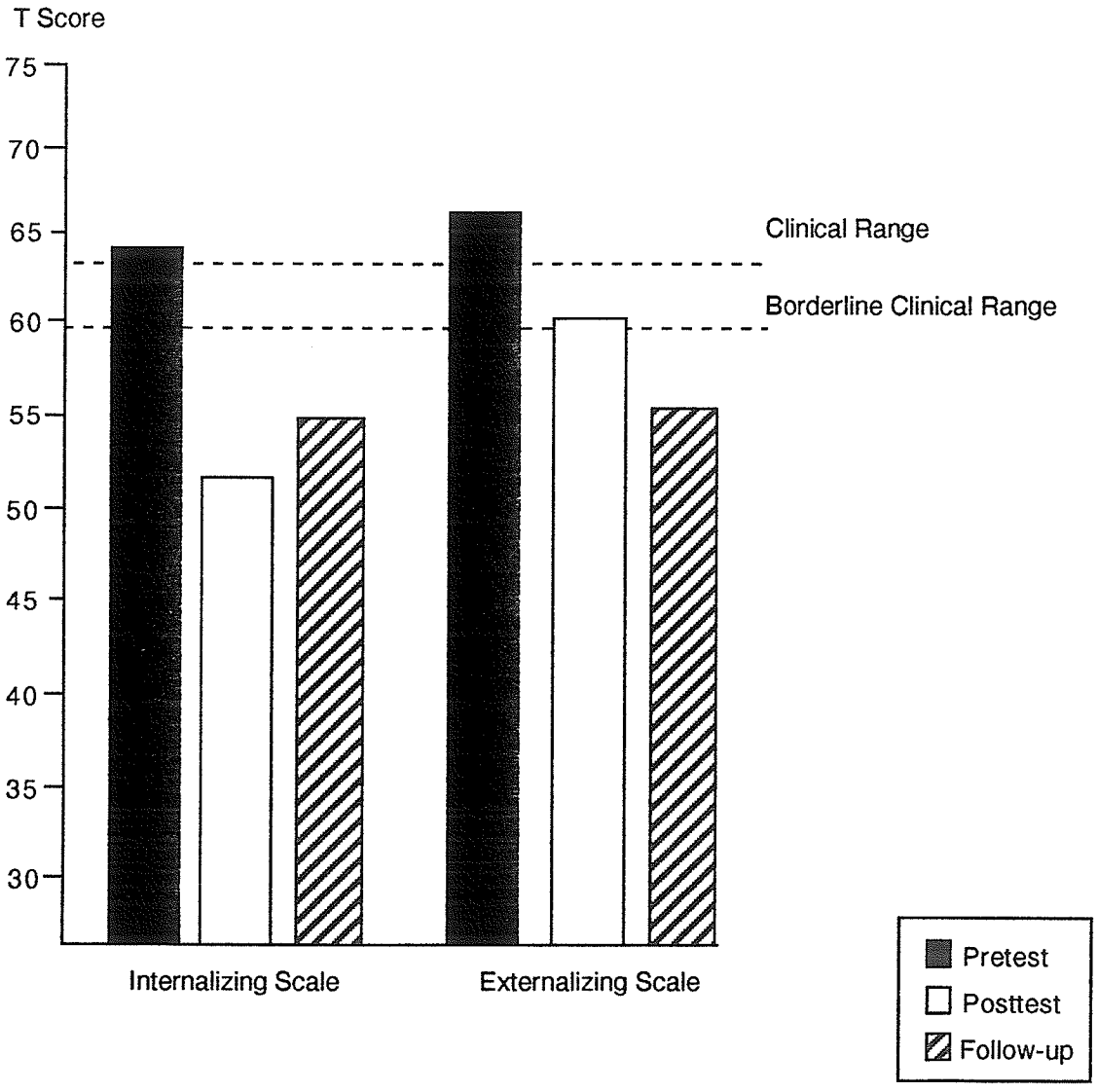

Figure 19. Child Behavior Checklist-Youth Self Report:
Family #2 --Child #1

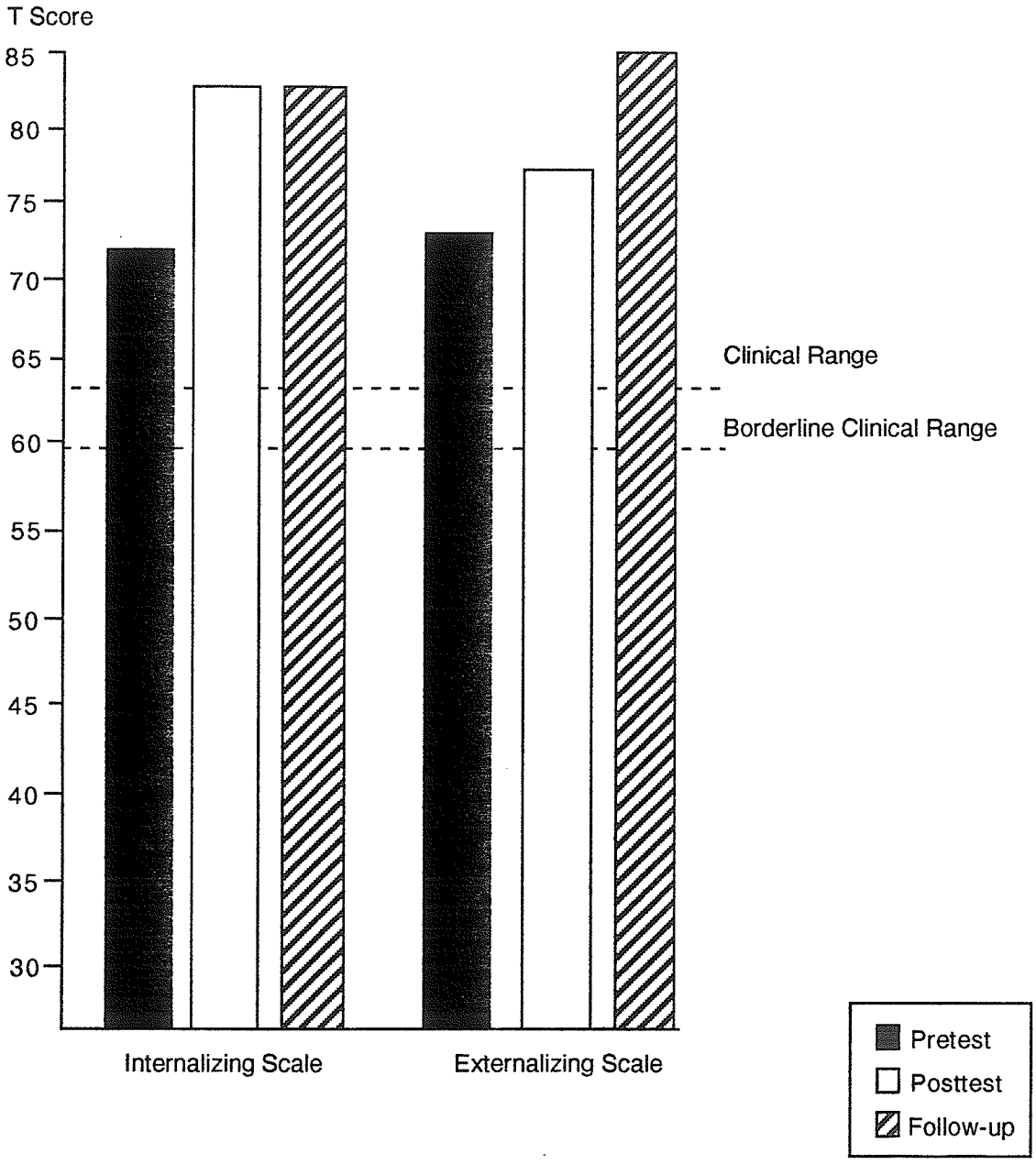

Figure 20. Child Behavior Checklist-Youth Self Report: Family #2 --Child #2

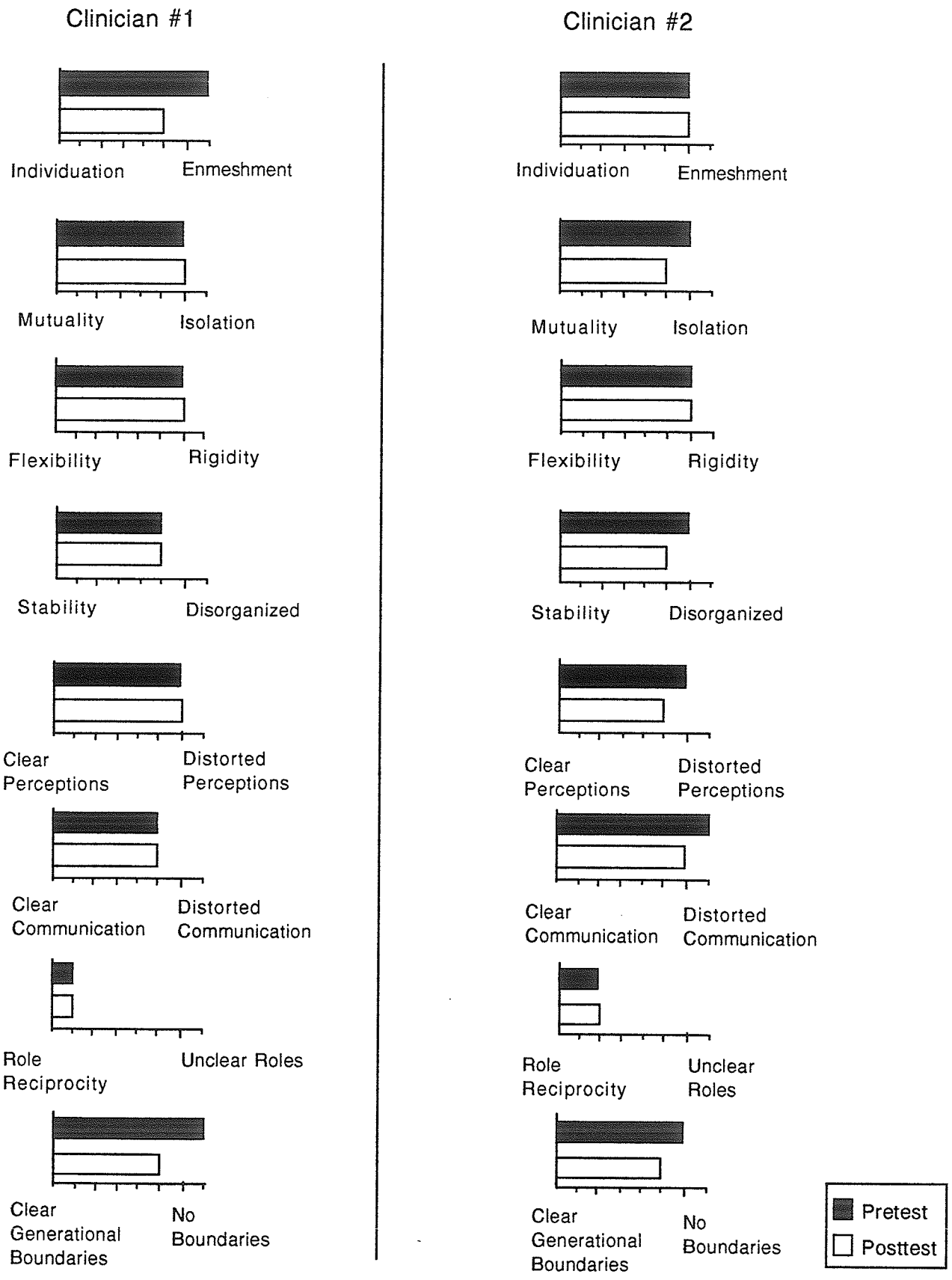

Figure 21. Family Characteristics Scale: Clinicians' Assessment of Family #2

Family #3

Description

Family #3 was a single mother with two sons (aged 12 and 11). The older son has Downs Syndrome and is severely cognitively impaired. He did not participate in the family therapy. (A genogram appears in Figure 22, p. 113.)

Description of Traumatic Experiences

The family was referred for family therapy because of the violent behaviour and suicidal ideations of the 11 year old son. At the time of the referral, the mother had recently ended a relationship with a man who physically abused her. Both children had witnessed the violence.

Formulation

The assessment indicated that the family was engaging in a number of life transitions, including transitions related to the emerging adolescent identity of the son. It was hypothesized that the strained, unclear and conflictual communication patterns between the mother and the son interfered with the family's ability to negotiate and adapt to change. Therefore, the area of family functioning targeted for intervention was communication.

Course of Treatment

Following three assessment sessions, the family attended five treatment sessions and a termination session. Many of the treatment sessions were conducted at the family's home because the mother lacked child care for her 12 year old son who has Downs Syndrome. Several

interventions were used to improve communication between the mother and her son including: instruction in communication skills, exercises to assist them to learn to identify and communicate feelings, and instruction in conflict resolution and problem-solving skills. The mother and son were encouraged to participate in enjoyable activities together. An intervention to increase the frequency of the boy's positive behaviour was the implementation of a token economy system.

The clinicians who worked with this family reported that in the first few treatment sessions, the mother frequently criticized her son and he would respond by "tuning out". In later sessions, after the mother was encouraged to reduce the frequency of her criticisms and to increase the frequency of positive comments, her son's level of tolerance for discussing issues of high emotional intensity increased.

Data

Family Functioning

The findings from the FACES suggest that the mother perceived her family to have a moderate level of cohesion at each of the three measurement points. Her conception of an ideal level of cohesion was at high end of the scale, which is described in FACES as enmeshed.

The family's level of adaptability, as measured by FACES, increased from a moderate level (i.e., structured) at the time of the pretest to an less functional level (i.e., chaotic) at the time of the posttest. It then reverted to a more moderate level (i.e. flexible) in the follow-up. The mother's view of an ideal level of adaptability for her family was in the high end of the scale (i.e., chaotic) at each of the three measurement points (Figure 23, p. 114).

The data from the FES suggest substantial improvement from the pretest to the posttest on several of the subscales, including cohesion, expressiveness, conflict, achievement orientation, intellectual orientation, active-recreational and moral-religious. The improvement was sustained or deteriorated only slightly in the follow-up. The data also suggest improvement in the independence of family members, and the level of organization and control in the follow-up (Table 12, p. 115).

The last measure of family functioning was the Family Characteristics Scale. The data from that measure suggest that, at the beginning of treatment, the mother perceived that the problematic areas of family functioning were a high level of disorganization in family interactions, and a lack of clarity in generational boundaries. The data from the posttest suggest that she perceived that family interactions had become more stable by the end of treatment. The posttest data also suggest that she perceived some deterioration in the extent to which the family was flexible and able to adjust to change, and an increase in the level of distortion in perceptions and communication patterns. However, there was improvement on each of these three dimensions in the follow-up data (Figure 24, p. 116).

Symptomatology: Mother

The findings for the BSI suggest that the mother's level of psychological distress, as measured by the general severity index, decreased substantially from the pretest to the posttest. This decrease was generally sustained in the follow-up (Table 13, p. 117).

The findings from the Trauma Sequelae do not suggest symptoms of PTSD at any of the three measurement points.

Symptomatology: Child

The mother completed the CBCL and CSBI only for her younger son. The findings from the CBCL suggest that the child's internalizing and externalizing behaviours decreased substantially from the pretest to the posttest, and the improvement was sustained in the follow-up. In the pretest, the data suggest that the child was in the clinical range for both internalizing and externalizing behaviours, but this decreased to a relatively low level in the posttest and follow-up (Figure 25, p. 118).

The findings from the Child Sexual Behavior Inventory, completed by the mother, were not suggestive of problematic sexual behaviours at any of the three measurement points.

Client Satisfaction

The mother indicated that she was very satisfied with the services she received from the clinicians, and that she would definitely use the program in the future if she required services.

Clinicians' Impressions of the Outcome of Treatment

The clinicians who provided services to this family judged treatment to be successful in improving communication patterns within the family. Family members were observed to have, and also reported, a better understanding and respect for each other, significantly less conflict, and an increase in positive behaviour toward one another.

Each clinician completed the Family Characteristics Scale at the beginning and end of treatment. The findings suggest that both clinicians perceived improvement on the dimensions of individuation versus enmeshment, and clear versus unclear perceptions. They also perceived

deterioration on the dimensions of role reciprocity versus unclear roles, and clear versus diffuse generational boundaries. Clinician #1 perceived improvement on the dimensions of mutuality versus isolation, flexibility versus rigidity, and clear versus distorted communication patterns. Clinician #2 perceived deterioration on the dimension of stability versus disorganization (Figure 26, p. 119).

Summary of Family #3

The presenting problem of this family was the 11 year old son's violent behaviour and suicidal ideations. There was also a high level of conflict between the mother and son.

The area of family functioning targeted for intervention was communication. Intervention was judged by the clinicians to be highly successful. They perceived that communication patterns had improved, and the level of conflict within the family had significantly decreased.

The findings from the self-report measures substantiate the clinical impressions. The measures of family functioning, completed by the mother, suggest improvements in several areas. The findings from the FES suggest improvement on family cohesion and expressiveness, and a significant decrease in the level of conflict. The findings from the Family Characteristics Scale suggest there was more stability in family interaction, and clearer perceptions, communications patterns, and role structuring. These improvements were sustained in the two month follow-up.

The mother's level of psychological distress, as measured by the BSI, decreased significantly over the course of the study. The son's internalizing and externalizing behaviours, as measured by the CBCL, decreased significantly.

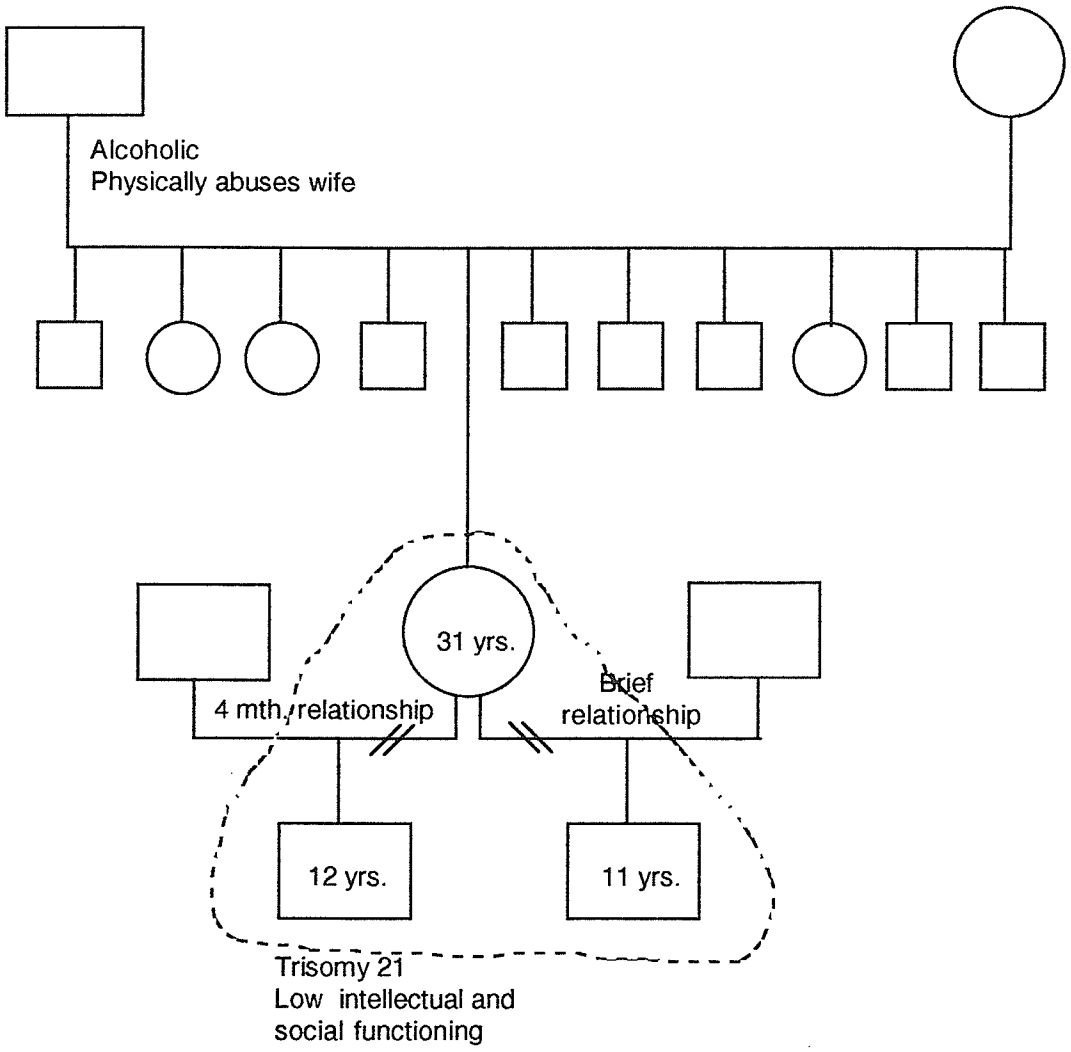

Figure 22. Genogram of Family #3.

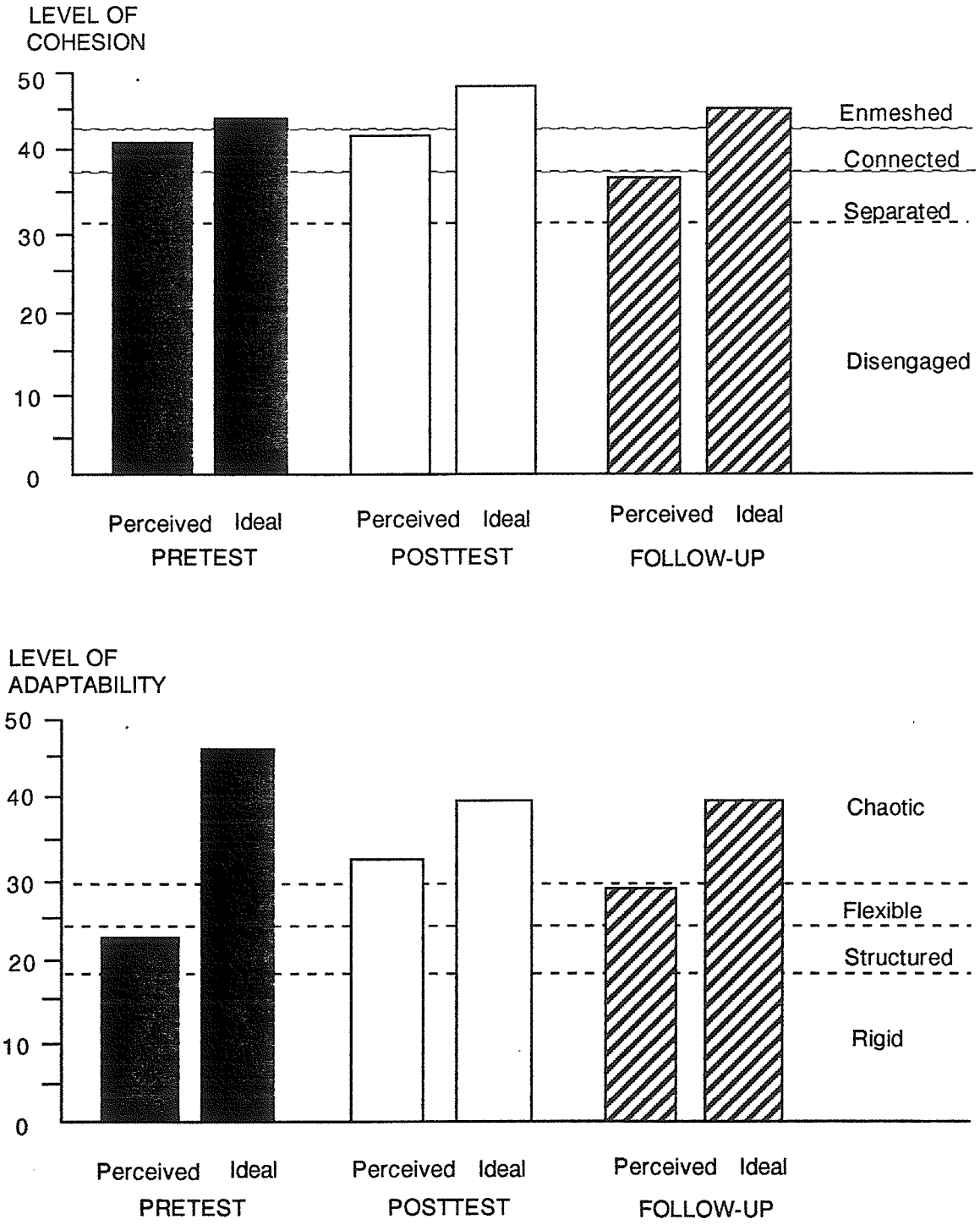

Figure 23. Family Adaptability and Cohesion Evaluation Scale: Family #3

Table 12

Family Environment Scale: Family # 3

(Standard Scores)

Scales	Pretest	Posttest	Follow-up
Relationship Dimensions:			
Cohesion	31	68	60
Expressiveness	47	66	60
Conflict	75	48	54
Personal Growth Dimensions:			
Independence	45	45	53
Achievement Orientation	28	60	47
Intellectual-Cultural Orientation	41	52	58
Active-Recreational Orientation	32	59	48
Moral-Religious Emphasis	41	56	56
System Maintenance Dimension:			
Organization	31	37	48
Control	48	48	59

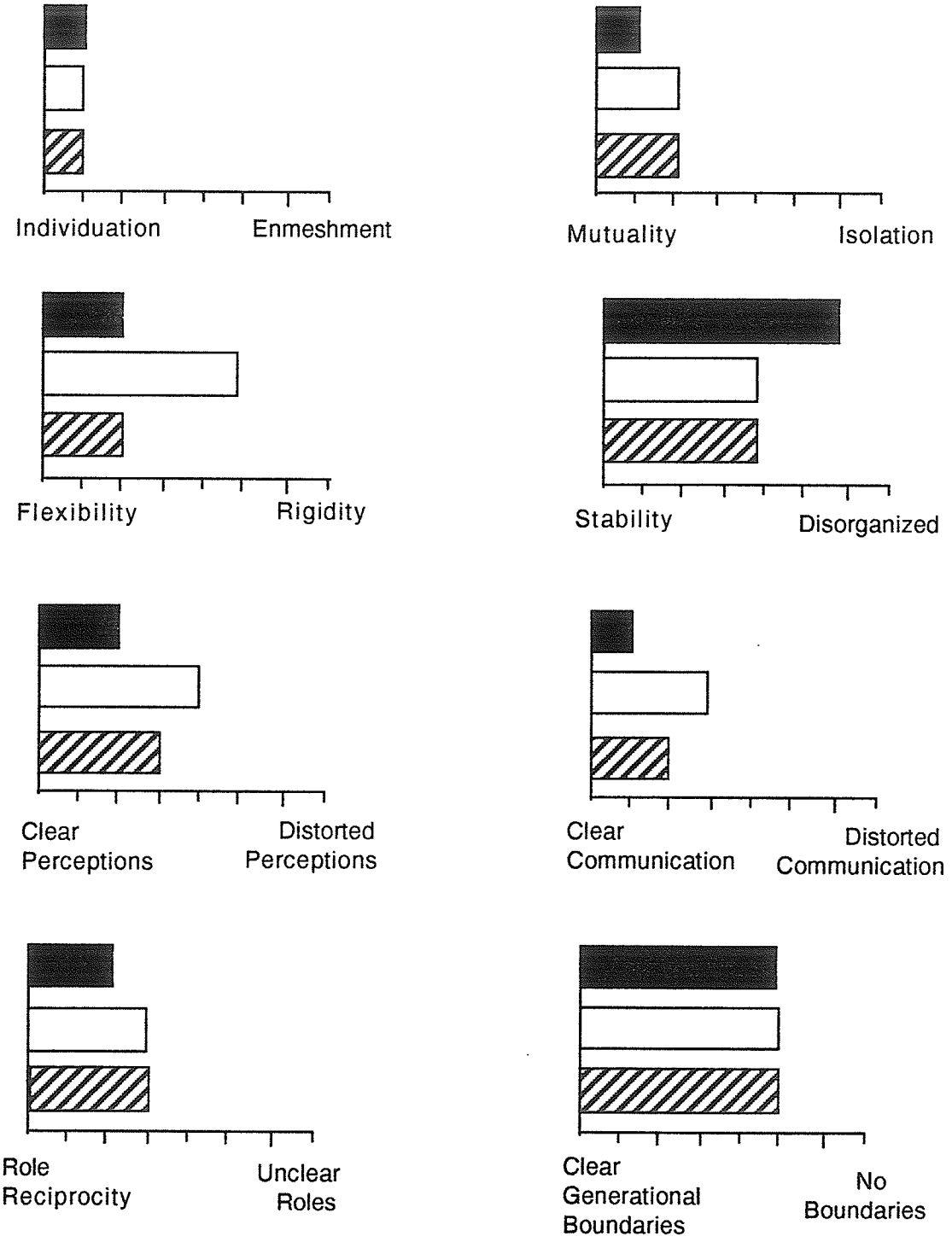

Figure 24. Family Characteristics Scale: Family #3

Table 13

Brief Symptom Inventory: Family #3

(T Scores)

Global Indices	Pretest	Posttest	Follow-up
Global Severity Index	41	19	24
Positive Symptom Distress Index	42	*	27
Positive Symptom Total	38	25	*

* denotes that the T score was too small to be calculated.

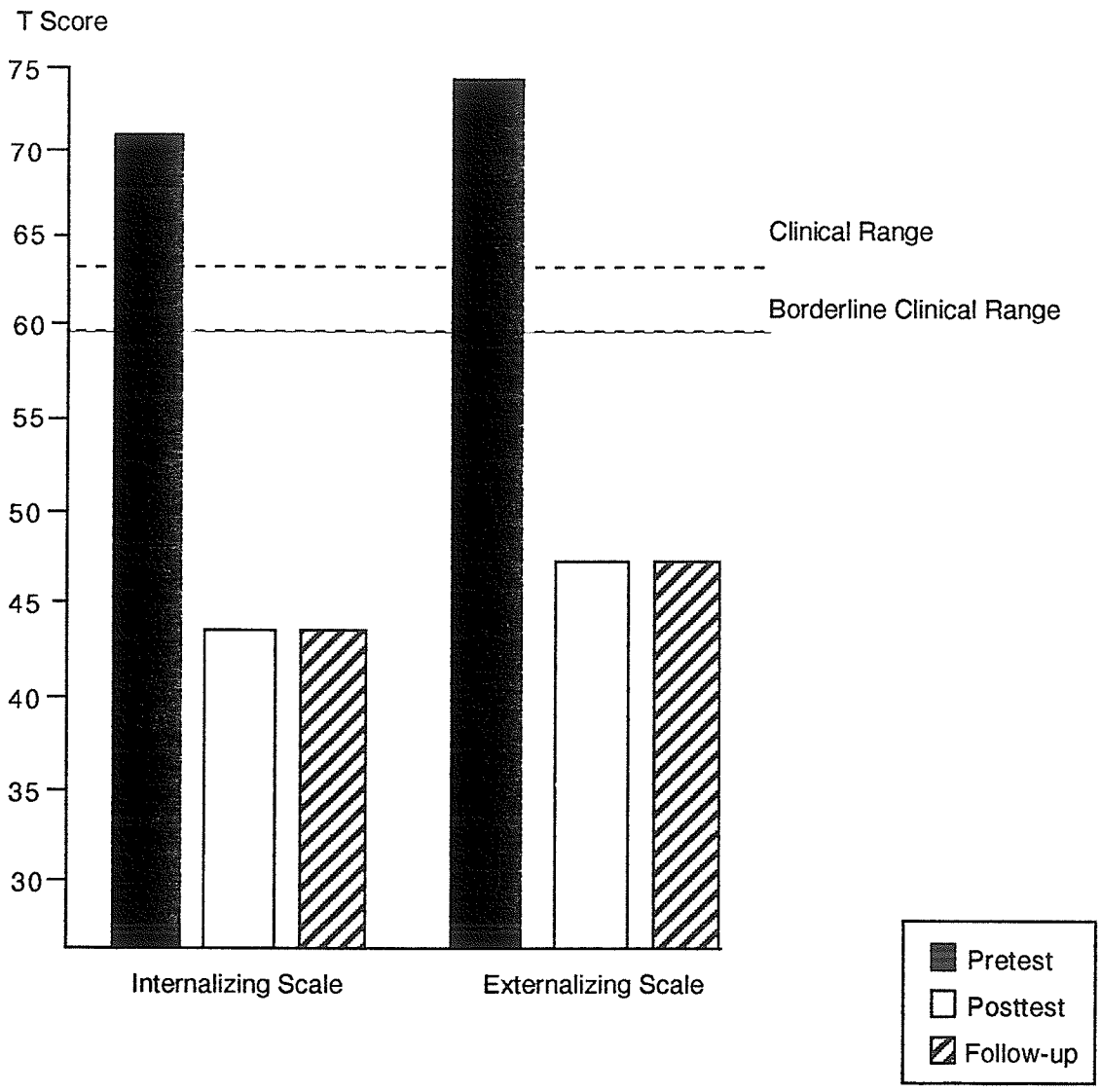

Figure 25. Child Behavior Checklist: Family #3

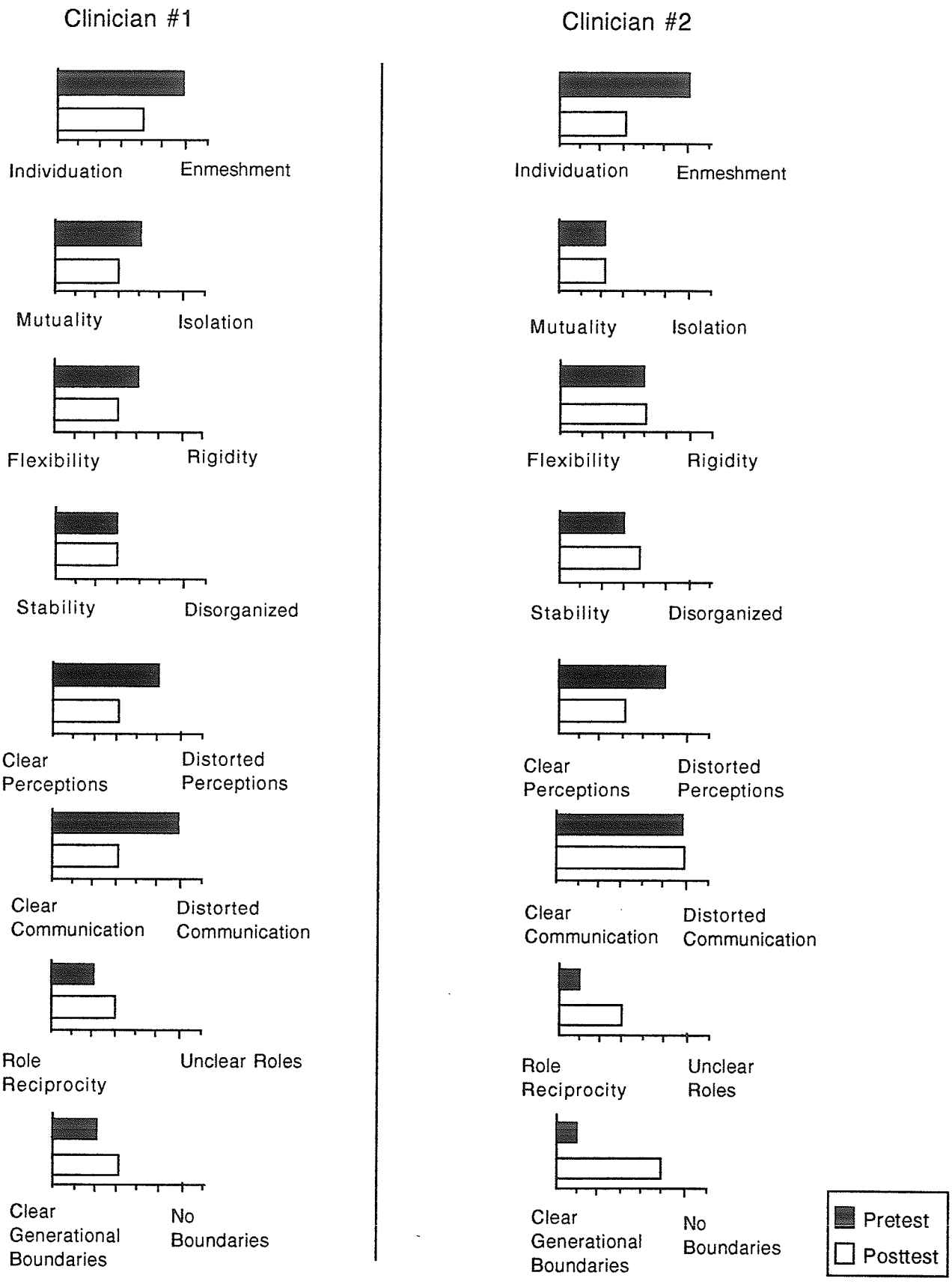

Figure 26. Family Characteristics Scale: Clinicians' Assessment of Family #3

Family #4

Description

Family #4 was a single mother with three children, two sons (aged 17 and 8), and a daughter (aged 15). (A genogram is in Figure 27, p. 126.)

Description of Traumatic Experience

The mother recently separated from her alcoholic husband and moved with their children to the city from a rural community. The children had witnessed their mother being physically and emotionally abused by their father. There was a high level of conflict within the family, especially between the mother and daughter, and the younger son was experiencing difficulties in school relating to his aggressive and acting out behaviour. Further, the mother recently was diagnosed as having multiple sclerosis.

Formulation

The area of family functioning targeted for intervention was communication patterns. The assessment indicated that the lack of effective communication within the family was a barrier to the family's ability to complete family life cycle developmental tasks. It had also eroded interpersonal relations such that the family functioned more as autonomous individuals than as a family unit.

Course of Treatment

The family attended three assessment sessions, six treatment sessions and a termination session. Interventions focused on encouraging family members to discuss family problems, and to express their feelings with each other. A relatively unstructured approach was used, and family

members were encouraged to decide which issues to discuss. The clinicians facilitated the discussions and assisted family member to learn to express their feelings. They also identified barriers to effective communication, and assisted family members to enhance their communication skills.

Data

Family Functioning

The findings from the FACES suggest that the mother perceived her family to have a low level of cohesion at each of the three measurement points. The data further suggest that the level of cohesion she considered to be ideal for her family was moderate level (Figure 28, p. 127).

In regard to adaptability, the findings suggest that in the pretest, the mother perceived her family to have a moderate level of adaptability (i.e., flexible). This increased in the posttest to the high end of the scale (i.e., chaotic), and decreased again in the follow-up to a more balanced level (Figure 28, p. 127).

The data from the FES suggest substantial improvements from the pretest to the posttest on the personal growth dimension, which includes the subscales of independence, achievement orientation, intellectual-cultural orientation, active-recreational orientation and moral-religious emphasis). These improvements were generally not sustained in the follow-up, and there was a substantial decrease in the level of independence of family members. The findings also suggest that the level of conflict in the family increased in the posttest, and this remained high in the follow-up. The extent to which rules and procedures are used to run family life, which is

measured by the control subscale, decreased substantially from the pretest to the posttest, then increased slightly in the follow-up (Table 14, p. 128).

The last measure of family functioning was the Family Characteristics Scale. The posttest findings suggest improvement on the dimensions of individuation versus enmeshment, mutuality versus isolation, flexibility versus rigidity, and clear versus diffuse generational boundaries. With the exception of generational boundaries, these improvements were not sustained in the follow-up. Deterioration was suggested on the dimensions of clear versus distorted perceptions, and clear versus distorted communication patterns (Figure 29, p. 129).

Symptomatology: Mother

The findings for the BSI suggest that the mother's level of psychological distress, as measured by the general severity index, was at a level considered to be moderate at each of the three measurement points (Table 15, p. 130).

The findings from the Trauma Sequelae are not indicative of symptoms of PTSD at any of the three measurement points.

Symptomatology: Children

The findings from the CBCL, completed by the mother for each of the children, suggest that in the posttest she perceived a decrease in the internalizing and externalizing behaviours of her sons (the oldest and youngest children). However, these improvements were not sustained in the follow-up for the oldest child (Figures 30a and 30b, p. 131-132).

The findings from the CSBI, completed by the mother for each of the children, were not suggestive of problematic sexualized behaviours.

The two oldest children completed the CBCL-Youth Self Report. The findings for older child suggest that, in contrast to the mother's perceptions, he did not consider internalizing or externalizing behaviours to be problematic for him at any measurement point (Figure 31, p. 133). The data also suggest that he saw improvements in his behaviour over the course of the study.

The findings for second oldest child suggest that she rated herself low on internalizing behaviours, and somewhat higher, but not in the clinical range, on externalizing behaviours. Further, the findings suggest that she perceived her internalizing and externalizing behaviours to increase over the course of the study (Figure 32, p. 134).

Client Satisfaction

The mother indicated that she was very satisfied with the services she received, and that she would definitely use the program in the future if she required services.

Clinicians' Impressions

The clinicians judged treatment to be somewhat successful in achieving the primary goal of improving communication patterns in the family. They observed an increased willingness among family members to discuss personal issues, including emotionally laden topics. However, the clinicians indicated that the mother and the youngest child continued to have issues stemming from their traumatic experiences, and individual therapy was recommended. Individual therapy had not commenced at the time of the follow-up.

The results from the Family Characteristics Scale, completed separately by the clinicians at the pretest and posttest, suggest the clinicians had rather different views of this family. The findings for clinician #1 suggest the family made small improvements on the dimensions of individuation versus enmeshment, flexibility versus rigidity, and clear versus distorted communication. Deteriorations were suggested on the dimensions of stability versus disorganization, and clear versus diffuse generational boundaries. In contrast, the findings for clinician #2 suggest improvement only on the dimension of clear versus distorted perceptions, and deteriorations on the dimension of individuation versus enmeshment (Figure 33, p. 135).

Summary of Family #4

This family was referred to family therapy because of a high level of conflict within the family, and because the youngest child was aggressive at school. The mother had recently left her alcoholic and abusive husband, and moved, with her children, to the city from a rural area. The younger son's behaviour problems coincided with the move. During the marriage, the children had witnessed the abuse of their mother by their father. The mother had been recently diagnosed as having multiple sclerosis.

The area of family functioning targeted for intervention was communication. The clinicians judged that the family had made some improvement in their communication. At the conclusion of treatment, the clinicians recommended individual therapy for the mother and the youngest child.

The self-report data generally suggest that at the end of treatment the mother perceived some improvements in family functioning, and in the

behaviour of her children. However, these improvements were not sustained in the follow-up.

The findings from the FES suggest that the mother perceived improvement on several dimensions of personal growth, which include subscales that measure the level of independence of family members, achievement orientation, intellectual orientation, active-recreational orientation, and moral-religious emphasis. These improvements were generally not sustained in the follow-up. She also reported an increased level of conflict, and a decrease in control (i.e., the extent to which rules and procedures are used to run family life).

In regard to individual functioning, the mother's level of psychological distress, as measured by the BSI, remained at a moderate level over the course of the study. The findings from the CBCL suggest that the children's behaviour had generally improved from the pretest to the posttest, but there was some deterioration in the follow-up. The two oldest children also completed the CBCL, and it is interesting to note that they perceived their own behaviour differently than did their mother. The oldest child perceived himself to be much lower than did his mother on the scales measuring internalizing and externalizing behaviours. The second child perceived herself to be lower than did her mother on internalizing behaviour. Her perceptions of her externalizing behaviour were similar to her mother's. They both perceived that her externalizing behaviour had increased over the course of the study.

The impressions of the clinicians, and the findings from the self-report data, suggest that the family did make some progress in treatment. However, the self-report findings suggest that the improvements made were generally not sustained.

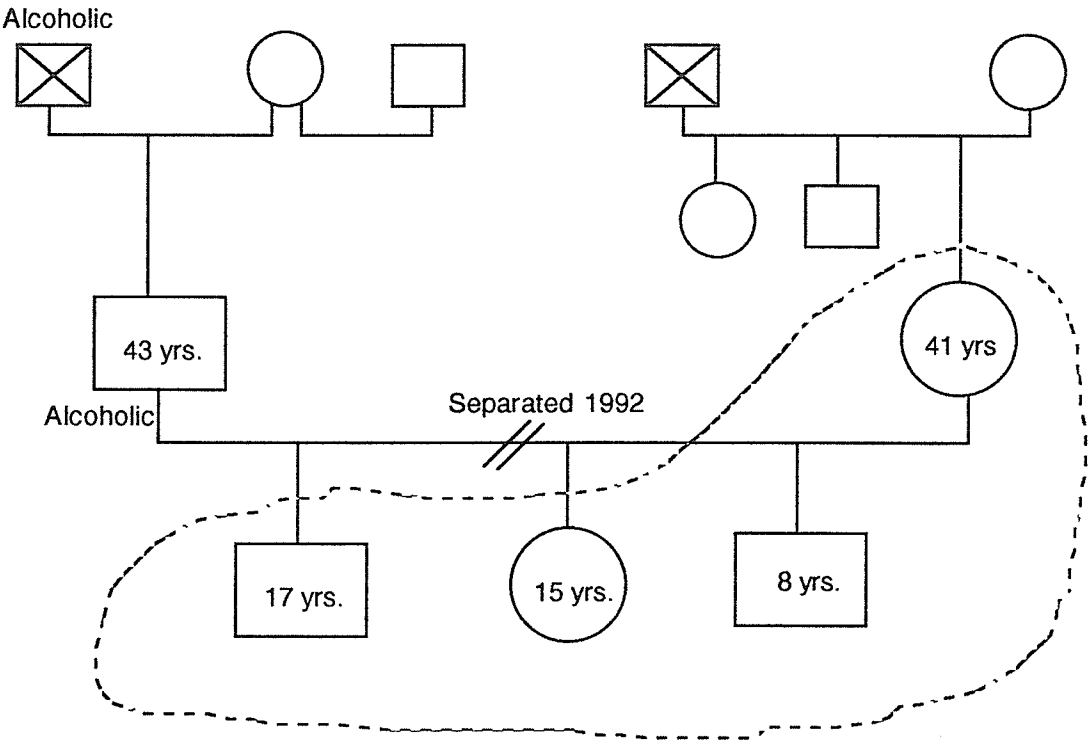

Figure 27. Genogram of Family #4.

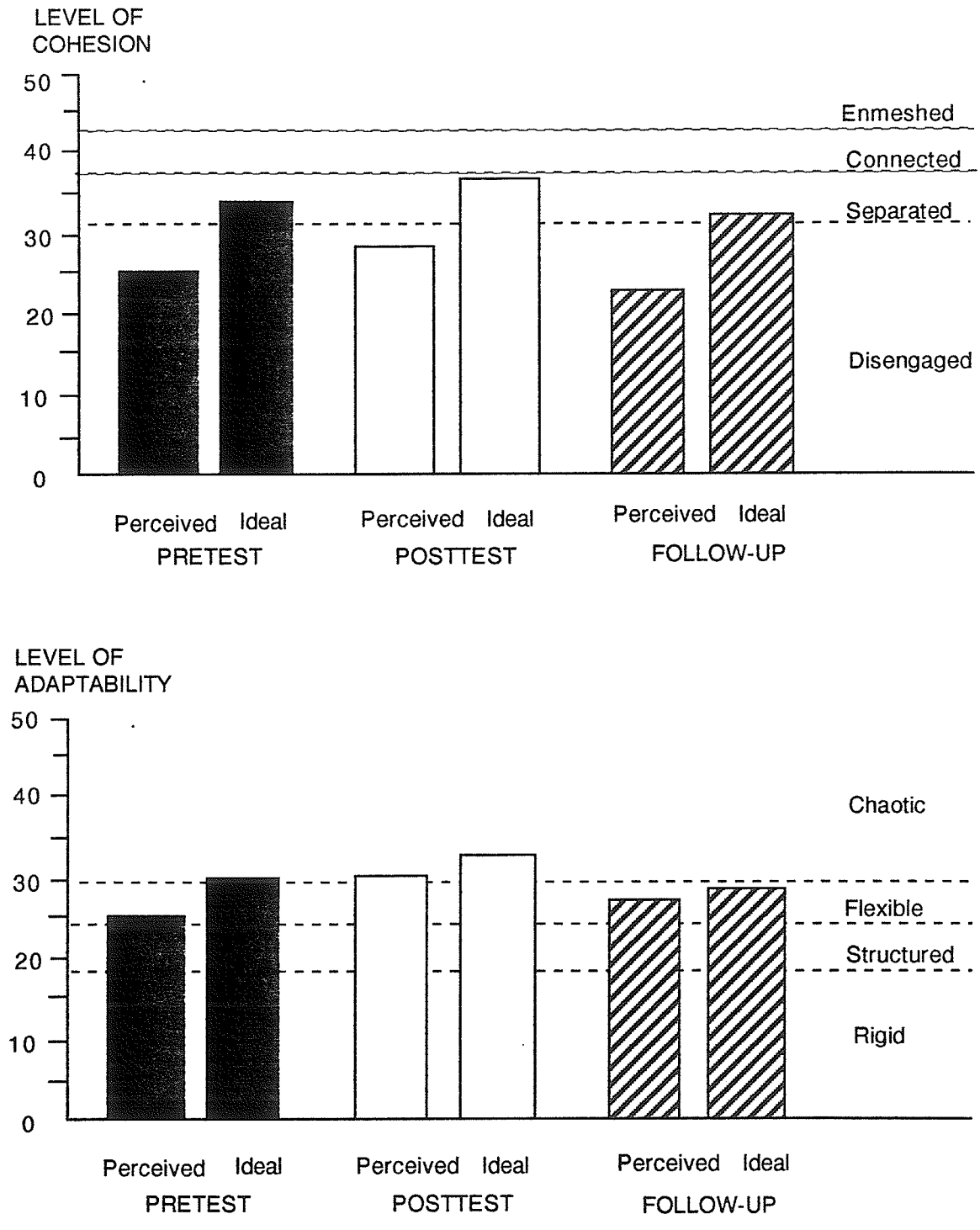

Figure 28. Family Adaptability and Cohesion Evaluation Scale: Family #4

Table 14

Family Environment Scale: Family # 4

(Standard Scores)

Scales	Pretest	Posttest	Follow-up
Relationship Dimensions:			
Cohesion	23	16	16
Expressiveness	41	41	41
Conflict	48	59	59
Personal Growth Dimensions:			
Independence	53	62	45
Achievement Orientation	41	53	53
Intellectual-Cultural Orientation	46	58	52
Active-Recreational Orientation	48	64	53
Moral-Religious Emphasis	51	62	56
System Maintenance Dimension:			
Organization	37	37	37
Control	48	26	37

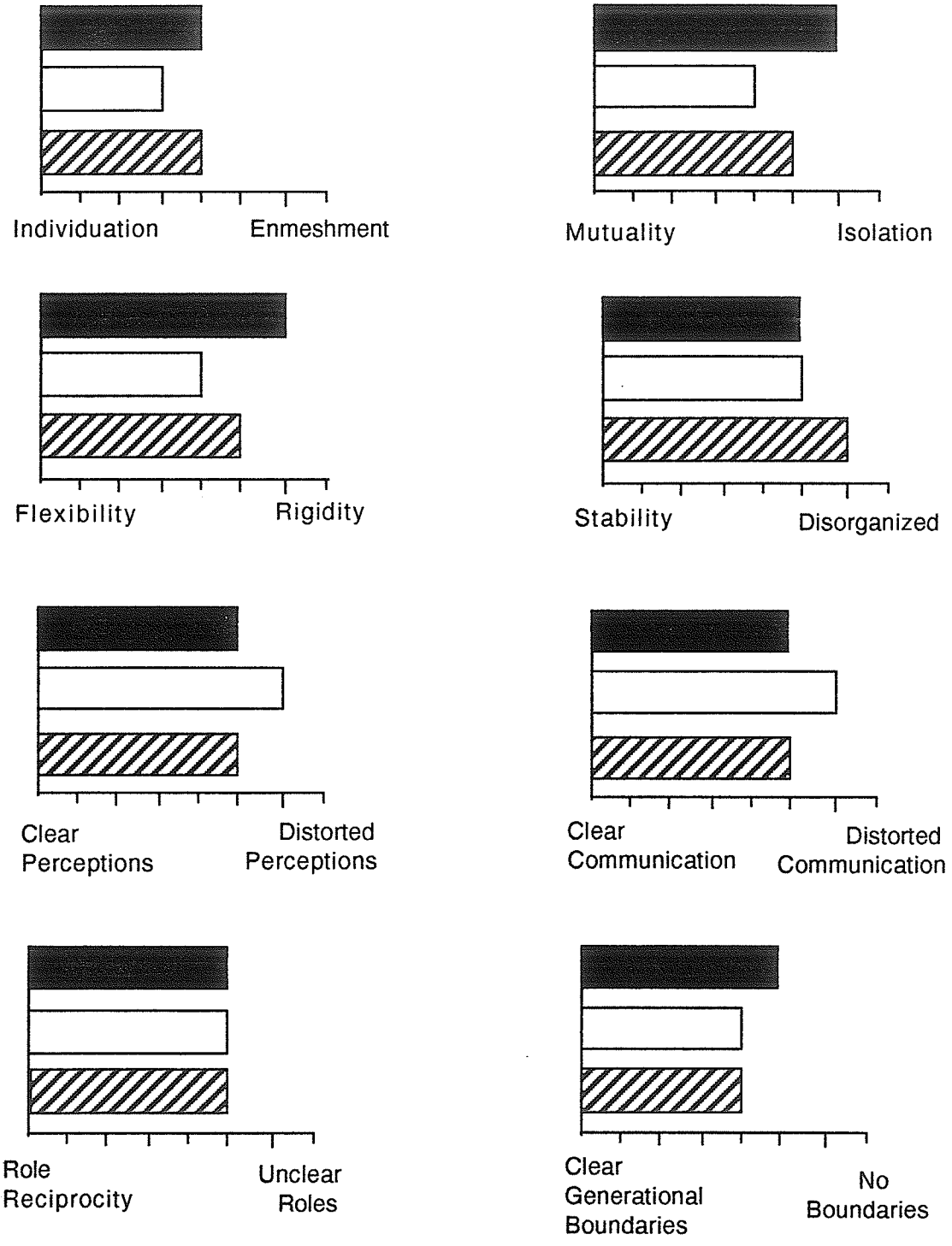

Figure 29. Family Characteristics Scale: Family #4

Table 15

Brief Symptom Inventory: Family #4

(T Scores)

Global Indices	Pretest	Posttest	Follow-up
Global Severity Index	46	41	47
Positive Symptom Distress Index	54	48	52
Positive Symptom Total	39	32	43

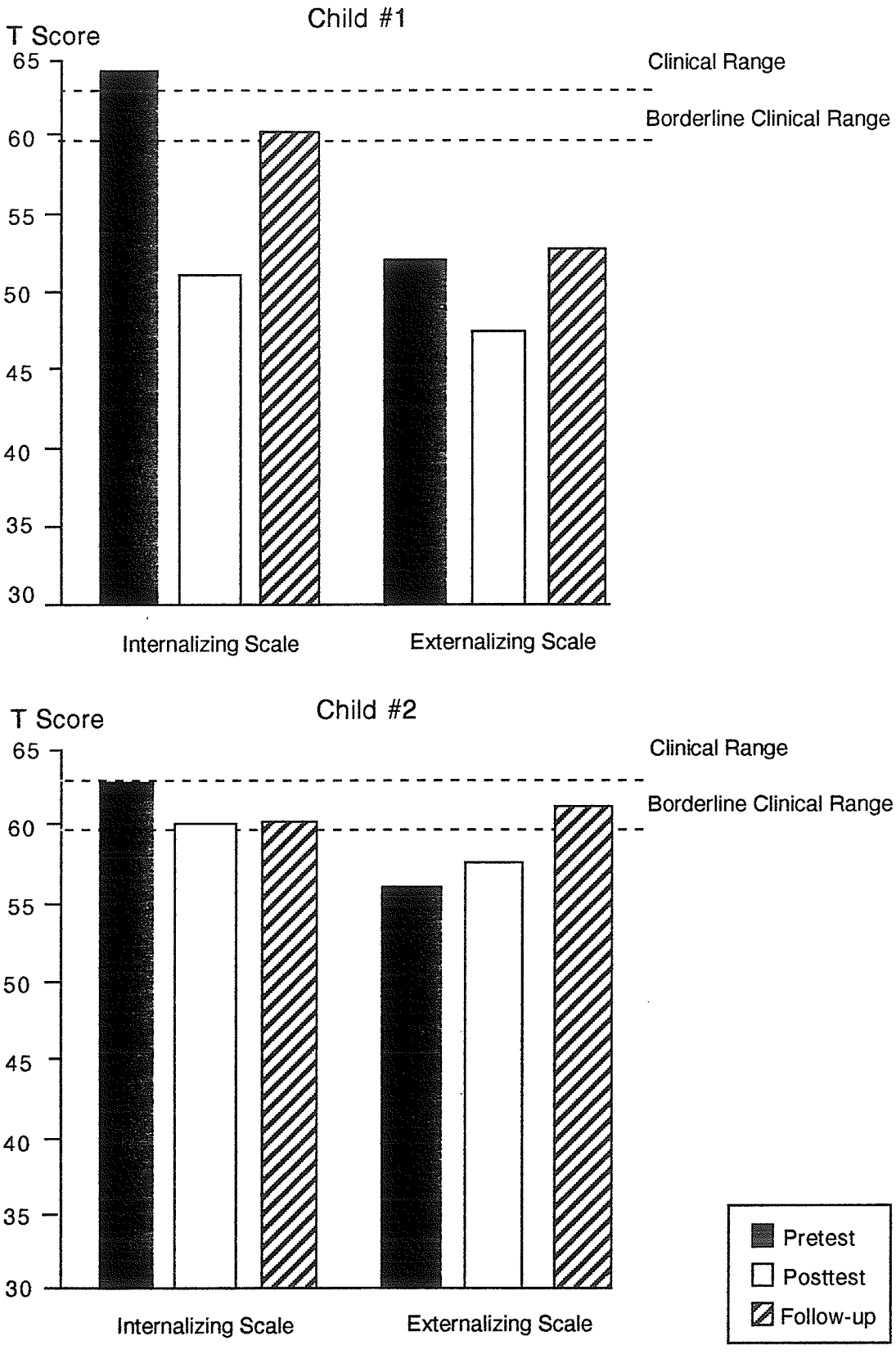

Figure 30a. Child Behavior Checklist: Family #4

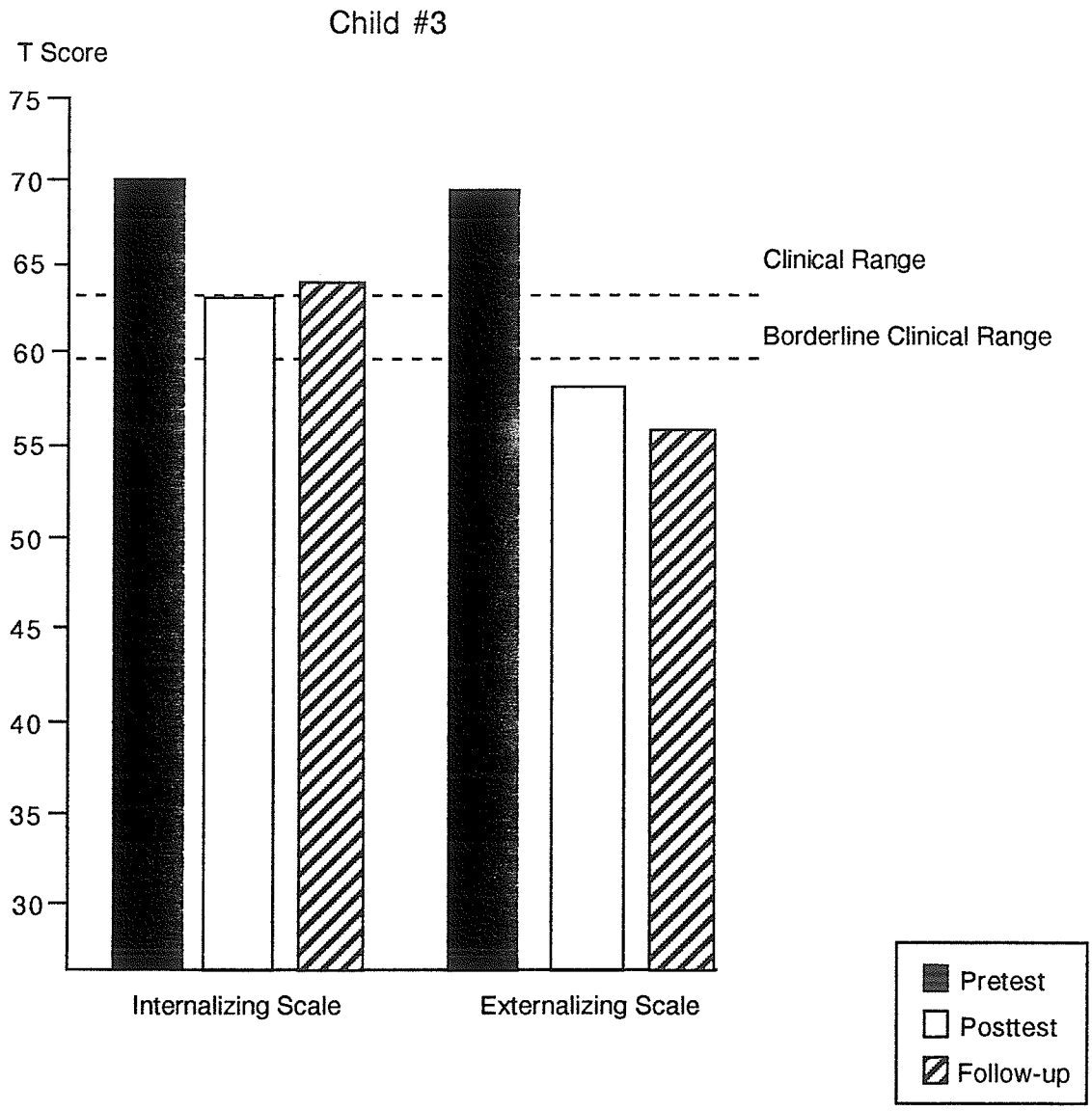

Figure 30b. Child Behavior Checklist: Family #4

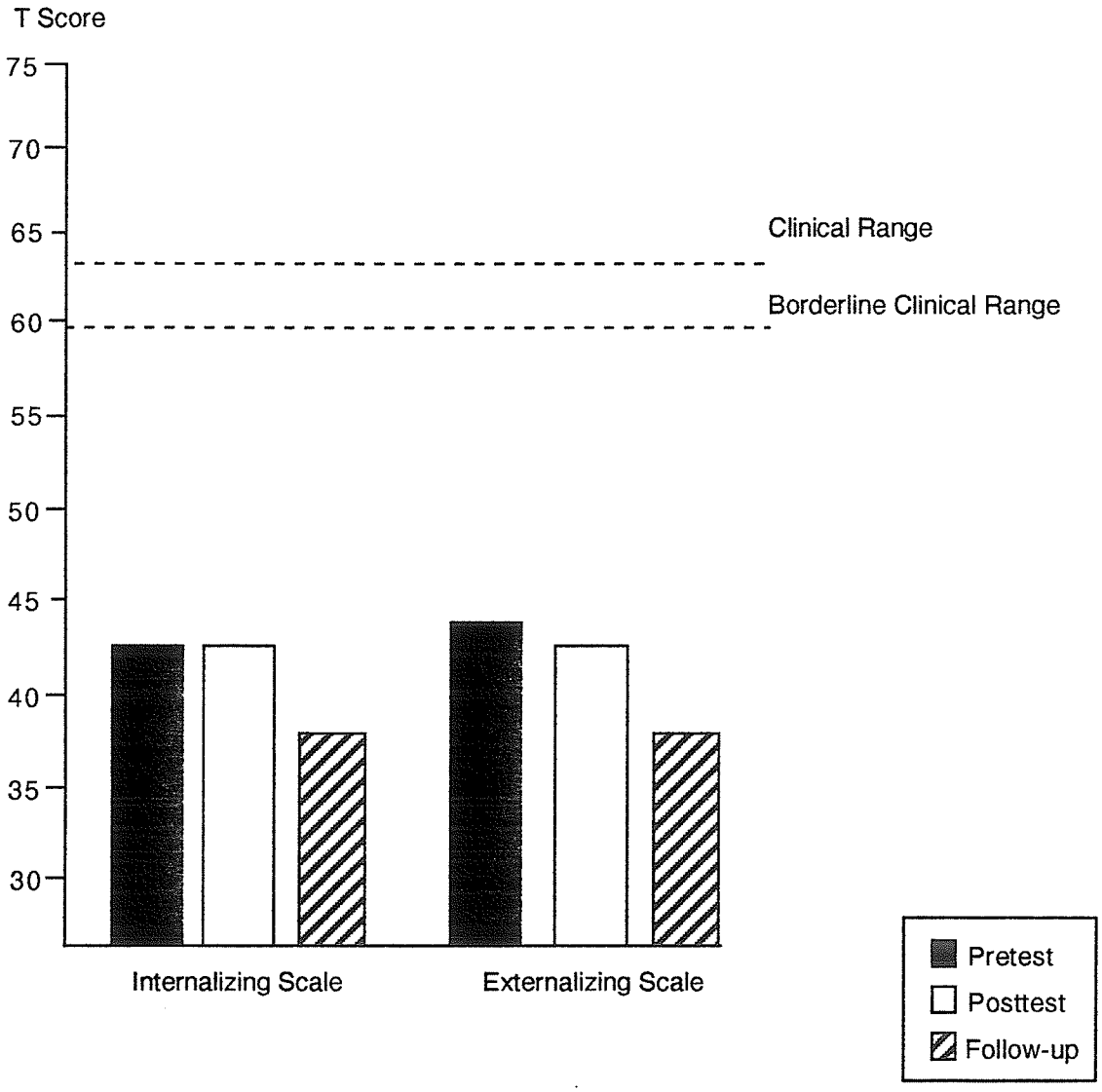

Figure 31. Child Behavior Checklist--Youth Self Report: Family #4 --Child #1

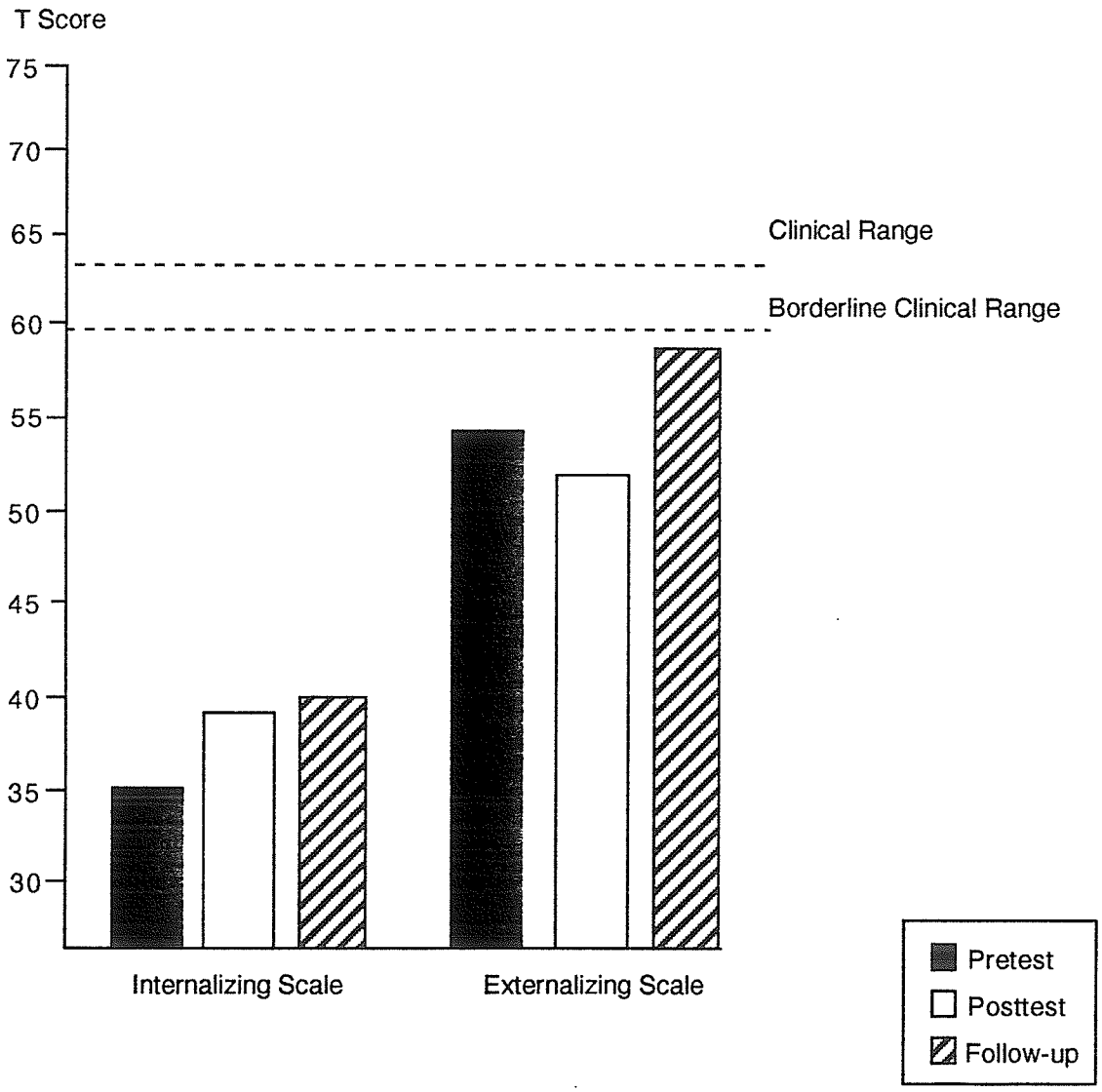

Figure 32. Child Behavior Checklist--Youth Self Report: Family #4 --Child #2

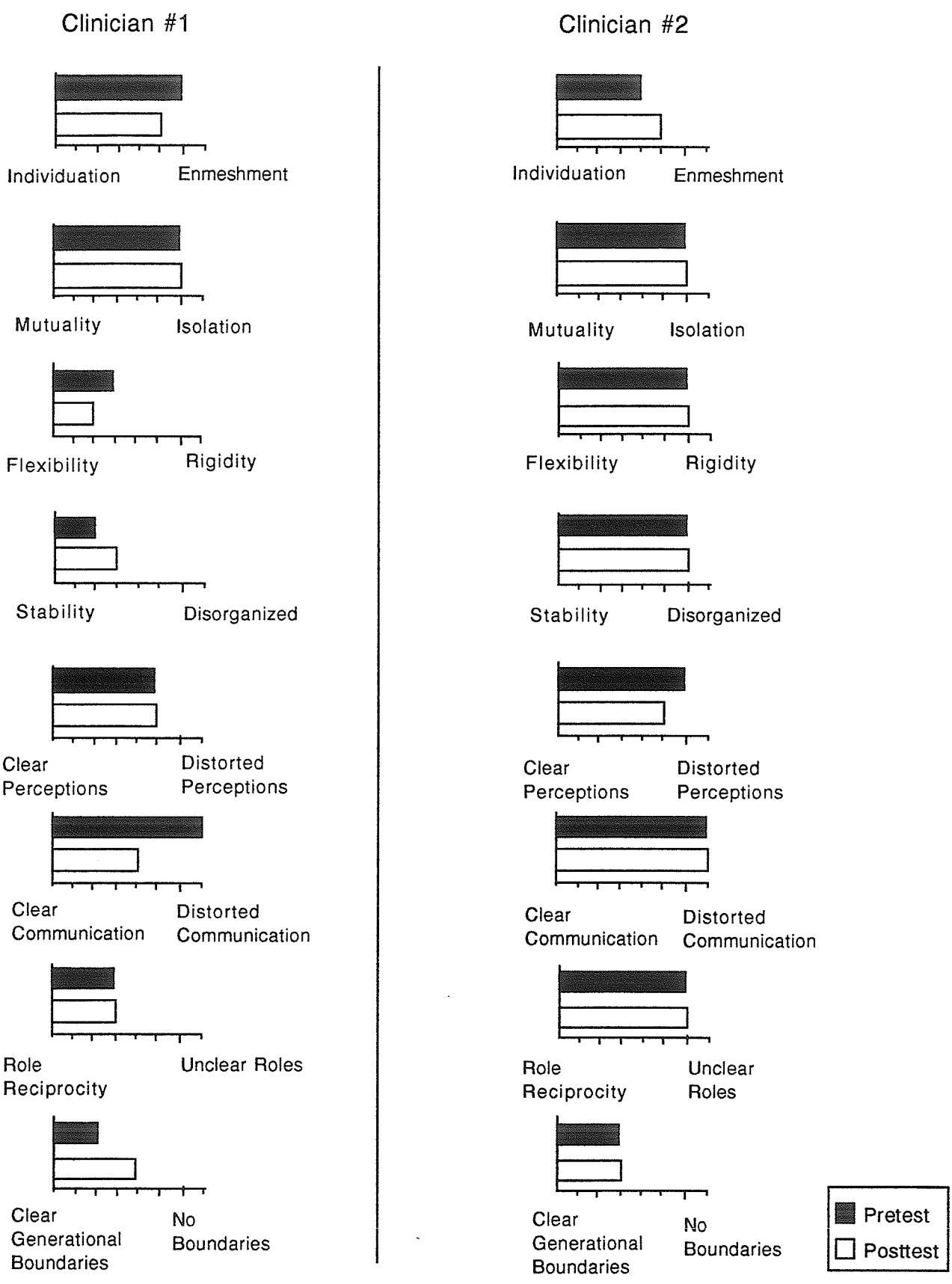

Figure 33. Family Characteristics Scale: Clinicians' Assessment of Family #4

Family #5

Description

Family #5 was a single mother with two children, a son (aged 11) and a daughter (aged 3). The family was of aboriginal ancestry. (A genogram is in Figure 34, p. 142.)

Description of Traumatic Experience

Until the age of 3, the son had often witnessed his father physically abusing his mother. This father left the family when the son was 3 years old. The son attempted to re-establish contact with his father when he was 9 years old, but the father literally told the boy that he did not love him. Following this incident, the son became very aggressive toward his mother and other children. He had threatened his mother with a knife, and was frequently in trouble at school for swearing, fighting, attacking others and threatening others with a knife.

Formulation

The area of family functioning targeted for intervention was role structuring. The clinicians assessed that the family seemed to be lacking in leadership and to be characterized by a high degree of role confusion. This manifested itself in increasing frustration and inappropriate parenting on the part of the mother, and a lack of structure for the children. It was hypothesized that the unclear status positioning and ambiguous roles in the family hierarchy seemed to be resulting in power struggles between the mother and her son.

Course of Treatment

The family attended three assessment and three treatment sessions. Since they had difficulty keeping appointments at the Clinic, the clinicians arranged to conduct sessions in the family's home. Initially this was well received by the family, but after three treatment sessions, they were not at home when the clinicians arrived for the scheduled sessions.

Several interventions were used to clarify the roles of family members, and to strengthen the mother's executive role. One intervention was to facilitate a discussion about their expectations of the parental and child roles, and to discuss changes they would like to see in their family in relation to these roles. A second intervention was to reframe the son's behaviour from an individual to a family context. The clinicians discussed how the behaviour of each family member influences the behaviour of the other family members. A third intervention focused on enhancing the mother's skills in providing her children with positive reinforcement. A final intervention was to encourage the family to spend time together in activities they all enjoyed.

Data

Family Functioning

The findings from the FACES suggest that the mother perceived her family's level of cohesion to increase substantially from the pretest to the posttest, then to decrease again in the follow-up measurement. Her concept of an ideal level of cohesion for her family was at the high end of the scale (i.e., enmeshed) (Figure 345, p. 143).

In regard to adaptability, the mother perceived her family to be on the low end of the scale (i.e., rigid) at each of the three measurement points.

Her concept of an ideal level of adaptability was at the high end of the scale (i.e., chaotic) (Figure 35, p. 143).

The FES was completed by the mother only in the pretest and follow-up. The findings suggest increases in family cohesiveness and the extent to which the family participates in social and recreational activities (i.e., active-recreational orientation). At the same time, the level of conflict decreased, as did the level of organization of the family (Table 16, p. 144).

The data from the Family Characteristics Scale, completed by the mother, suggest significant improvement on the dimensions of mutuality versus isolation, and stability versus disorganization. The improvement on the latter was not sustained in the follow-up (Figure 36, p. 145).

Symptomatology: Mother

The findings for the BSI suggest that the mother's level of psychological distress was low at the time of the pretest and the follow-up. The posttest data were incomplete (Table 17, p. 146).

The mother chose not to complete the Trauma Sequelae at any of the measurement points.

Symptomatology: Child

The mother completed the CBCL for her son at the pretest and the follow-up. The findings suggest that his internalizing and externalizing behaviours did not change over the course of the study. His score on the externalizing behaviours scale was in the clinical range (Figure 37, p. 147).

The child completed the CBCL - Youth Self-Report in the pretest only. The findings suggest that he was in the clinical range on the scales measuring internalizing and externalizing behaviours.

The findings from the CSBI, completed by the mother in the pretest and follow-up, were not suggestive of problematic sexualized behaviours.

Client Satisfaction

The mother indicated that she was mostly satisfied with the services she received from the clinicians, and that she would definitely use the program in the future if she required services.

Clinicians' Impressions of the Outcome of Treatment

The family attended three assessment sessions and three treatment sessions, and then withdrew from treatment. The clinicians judged that they had made some progress in terms of achieving their therapeutic goals. They perceived that the mother's confidence in her role as mother and in her executive capacity increased, and the son's noncompliant and acting-out behaviour seemed to decrease. The mother and son were spending more time together engaged in activities and events that they chose and planned together. The clinicians also perceived some progress in terms of helping the mother to understand her son's behaviour problems within the context of the family. That is, she seemed to develop a better understanding of how the behaviour of each family member, including herself, influenced the behaviour of other family members.

The findings from the Family Characteristics Scale, completed separately by each clinician at the beginning and at the end of treatment, suggest that both clinicians perceived improvement on the dimensions individuation versus enmeshment, mutuality versus isolation, and role reciprocity versus unclear roles. In addition, clinician #2 perceived improvements on the change dimension (i.e., flexibility versus rigidity, and

stability versus disorganization), and on the dimension of clear versus distorted communication patterns (Figure 38, p. 148).

Summary of Family #5

This family was referred to family therapy because of the aggressive and violent behaviour of the 11 year old son. He had threatened his mother with a knife, and there were frequent incidents of aggressive and violent behaviour at school. In his early childhood, the child had witnessed his father physically abuse his mother. The mother suggested that it was traumatic for the son when he lost contact with his father, and that it was also traumatic when he attempted without success to re-establish contact. The father told the boy that he did not love him. The boy was 9 years old at the time. This coincided with the onset of his violent and aggressive behaviour.

The area of family functioning targeted for intervention was role structuring. Although the family did not complete the treatment plan, the clinicians judged that they had made some progress in strengthening the mother's executive capacity, increasing the amount of time the mother and son spent together, and decreasing the son's aggressive and acting out behaviour.

The findings from the self-report measures suggest some small improvements in some areas of family functioning. The findings from the Family Characteristics Scale suggest that the mother perceived her family to achieve a greater sense of mutuality over the course of the study. The FES data suggest small increases in family cohesiveness, and the extent to which the family participates in social and recreational activities. Further, the mother perceived the level of conflict within the family to decrease.

The self-report findings from the CBCL, completed by the mother, suggest that her son's externalizing behaviours were in the clinical range in both the pretest and the follow-up. The son also completed the CBCL -- Youth Self Report in the pretest only. The findings suggest that both his internalizing and externalizing behaviour were in the clinical range.

Overall, it is difficult to draw conclusions about the impact of intervention on this family. The family withdrew from treatment after only three sessions, and at the time of the follow-up, the mother reported that her son had been involved in further violent incidents at school.

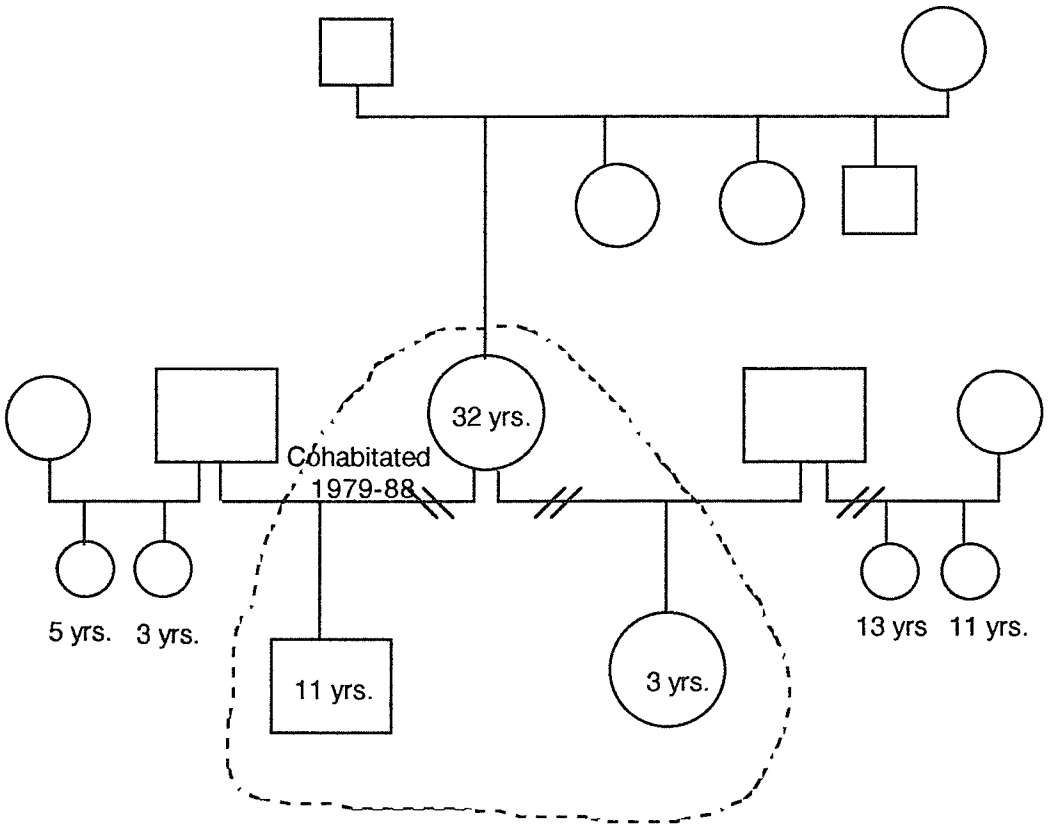

Figure 34. Genogram of Family #5.

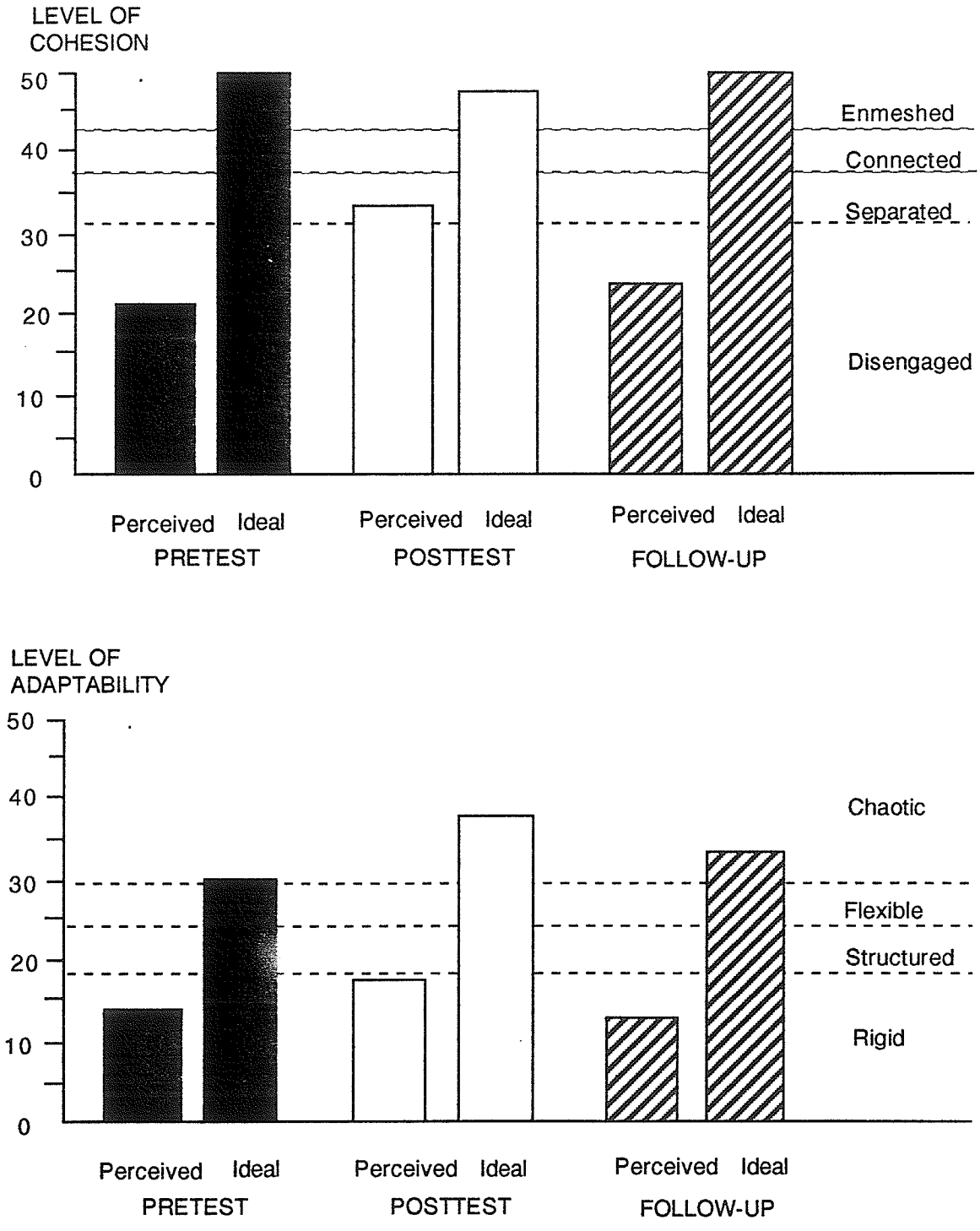

Figure 35. Family Adaptability and Cohesion Evaluation Scale: Family #5

Table 16

Family Environment Scale: Family # 5

(Standard Scores)

Scales	Pretest	Posttest*	Follow-up
Relationship Dimensions:			
Cohesion	38		46
Expressiveness	41		34
Conflict	70		59
Personal Growth Dimensions:			
Independence	28		36
Achievement Orientation	47		53
Intellectual-Cultural Orientation	46		46
Active-Recreational Orientation	48		59
Moral-Religious Emphasis	41		46
System Maintenance Dimension:			
Organization	37		26
Control	70		65

* Postest results were incomplete.

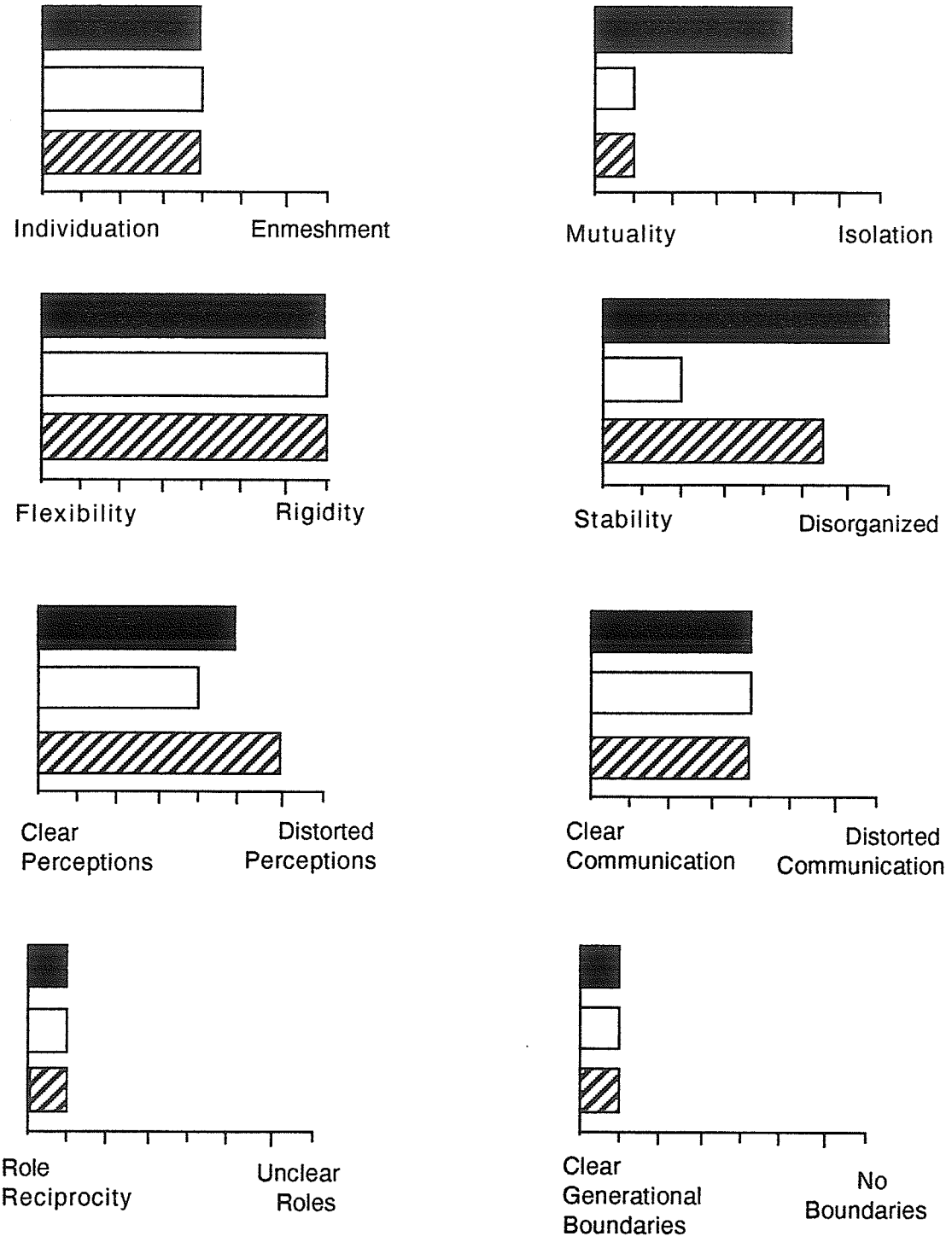

Figure 36. Family Characteristics Scale: Family #5

Table 17

Brief Symptom Inventory: Family #5

(T Scores)

Global Indices	Pretest	Posttest*	Follow-up
Global Severity Index	29		34
Positive Symptom Distress Index	31		36
Positive Symptom Total	25		25

* Posttest data were incomplete.

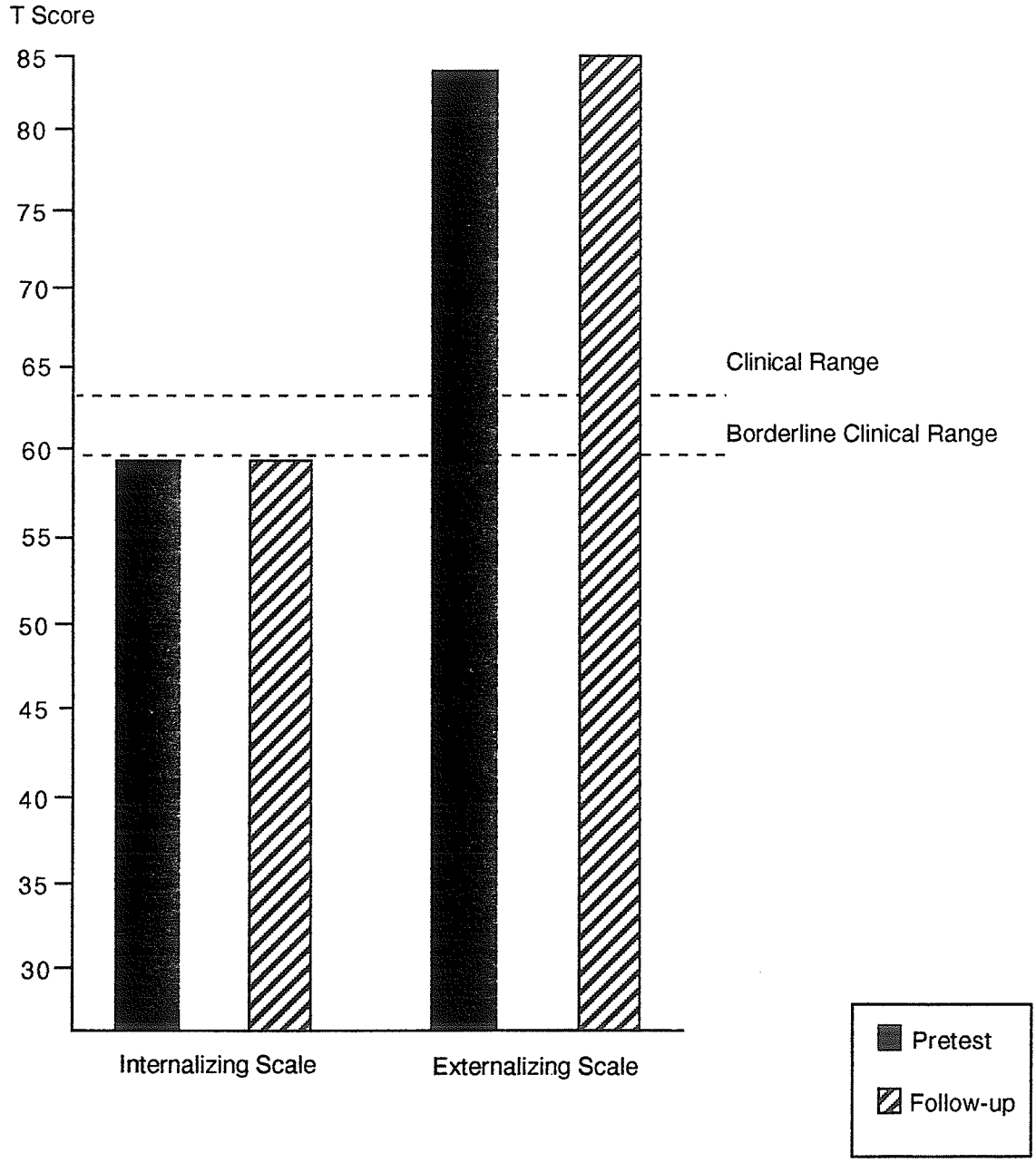

Figure 37. Child Behavior Checklist: Family #5
(Posttest data were incomplete.)

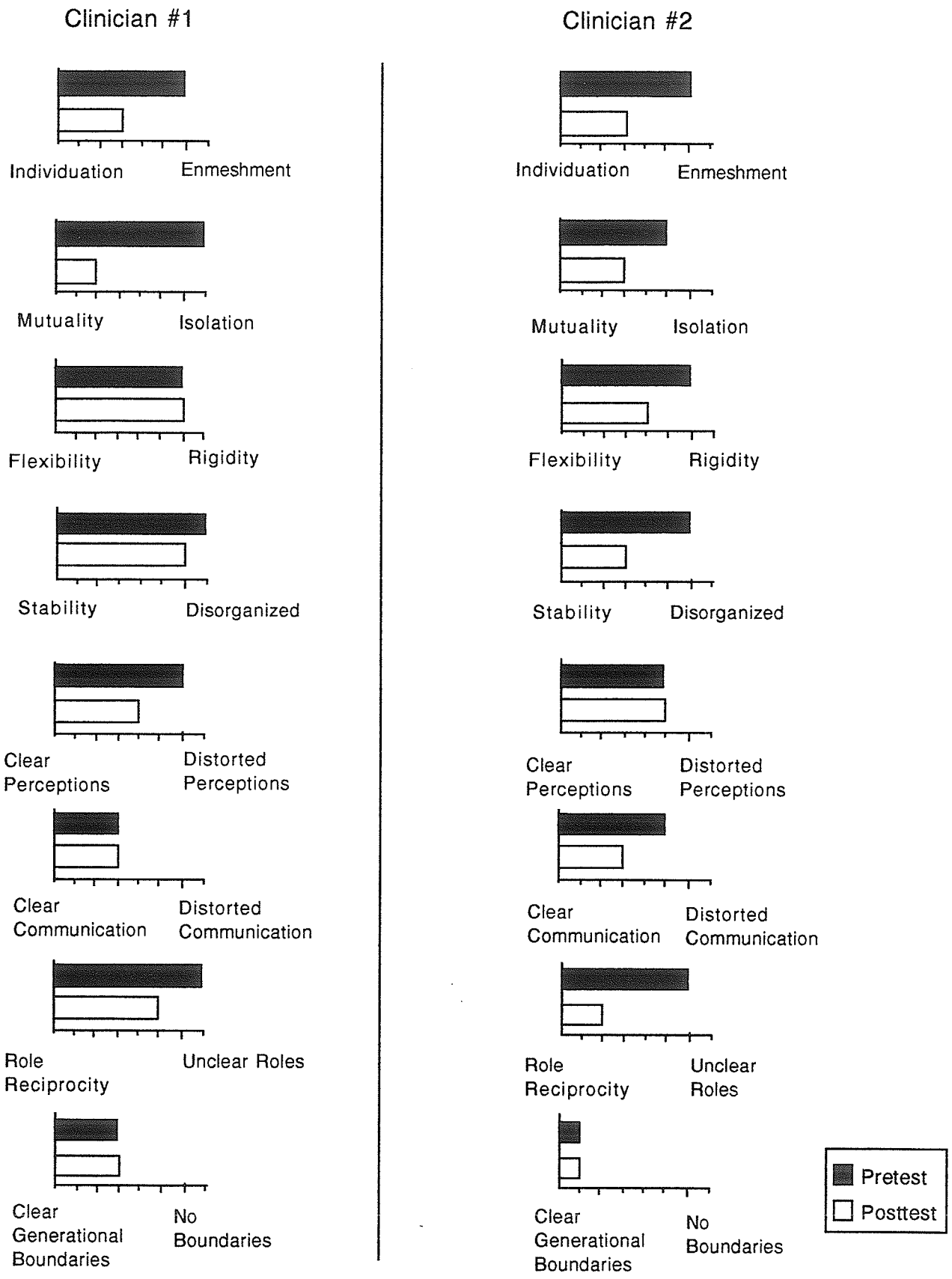

Figure 38. Family Characteristics Scale: Clinicians' Assessment of Family #5

Chapter 5

Discussion

The goal of this study was to evaluate the efficacy of a short-term, intensive intervention approach for traumatized families. There were three research objectives:

1) To measure the effectiveness of the treatment approach in reducing the symptoms of traumatic stress on individual family members;
2) To evaluate the impact of the treatment approach on family functioning;
3) To measure whether a change in one dimension of family functioning has an impact on other dimensions of family functioning.

Research Goal

The five families who participated in the study were heterogeneous. Two were two-parent families and three were single-parent families. The number and ages of the children in the families varied, as did the nature of the trauma experienced. All of the families had experienced long-term chronic trauma.

Subjective methods (clinician's impressions) and objective methods (self-report measures) methods were used to measure the impact of treatment. The results suggest that four of the five families made at least some improvement in some areas of individual and family functioning. Treatment was clearly effective for one of the five families (Family #3). Three families were judged to have made some improvement, though further treatment was recommended (Families #1, #2, and #4). The fifth family (Family #5) withdrew from treatment after attending three assessment sessions and three treatment sessions.

In general, the results suggest that the treatment approach can be effective for traumatized families. However, the fact that at the conclusion of treatment, three of the five families required further treatment suggests that the length of the intervention approach is insufficient to promote sustained improvement in traumatized families. The results of the study also reveal the complexity of evaluating treatment outcome and, in particular, the problems inherent in relying on self-report measures of family functioning.

Family #3, for whom treatment was effective, was a single-parent family. The presenting problem was aggressive behaviour on the part of the 11 year old son, and a high level of conflict between him and his mother. The treatment plan focused on communication. The clinicians reported that the family made substantial progress in therapy. That conclusion was substantiated by the self-report data, which suggested improvement on several dimensions of family functioning, including increased family cohesion, expressiveness, communication and role structuring, and decreased family conflict. The self-report data also suggested improvement in individual functioning. The mother's level of psychological distress decreased, as did the son's internalizing and externalizing behaviour. The improvements suggested in the self-report measures were sustained in the follow-up.

All three families for whom further treatment was recommended agreed to attend additional sessions. However, Family #1 attended only two treatment sessions, and Family #4 did not attend any additional sessions, before the follow-up measures were administered. This could suggest difficulty in maintaining a family's motivation for therapy for more than a relatively short time. Family #2 attended four additional treatment sessions before the follow-up measurement. The clinicians' impressions and the self-

report data suggest that while some progress was made in therapy, significant problems continued in several areas of family functioning and individual functioning. During the course of treatment, the children in this family chose to attend only one treatment session.

Family #5 withdrew from treatment after attending three assessment sessions and three treatment sessions. This family continued to experience problems over the course of the study. In the follow-up, the mother indicated that she was satisfied with the services she had received and would use the services again, but she also reported that her 11 year old son continued to have problems at school relating to his aggressive and violent behaviour. The clinicians perceived that the family had made some progress in improving family functioning and in reducing the level of family conflict. The self-report data also suggest that some progress was made in some areas of family functioning, such as on the subscales of cohesion, conflict, and active-recreational orientation in the FES. However, deterioration was suggested on other dimensions, such as on the subscales of organization and expressiveness. Further, the results of the CBCL that were administered in the follow-up suggest that the son's externalizing behaviour remained in the clinical range.

Research Objectives

Impact of Treatment on Individual Family Members

The first research objective was to measure the effectiveness of the treatment approach in reducing the symptoms of traumatic stress on individual family members. The results of the self-report measures indicate that, over the course of the study, the symptoms of psychological distress and PTSD decreased for four of the seven parents in the study. They were

three of the four parents in the two-parent families, and the single-mother in the family for whom treatment was successful. Psychological distress was measured by the BSI, and PTSD was measured by the Trauma Sequelae.

Symptoms of psychological distress decreased for the mothers in Families #2 and #3. The mother in Family #1 also had fewer symptoms of psychological distress in the posttest, but the decrease was not sustained in the follow-up. The father in Family #2 had fewer symptoms of psychological distress in the follow-up than in the posttest. His level of psychological distress could have been influenced by the additional treatment sessions the family attended between the posttest and the follow-up, and by his wife's use of anti-depressant medication, which began shortly before the posttest.

With respect to PTSD, two of the adults in the study had symptoms of PTSD in the pretest. These were the mothers in each of the two-parent families. The mother in Family #2 had symptoms that were consistent with a diagnosis of PTSD in the pretest and the posttest. The symptoms subsided at the time of the follow-up, but were consistent with a diagnosis of partial PTSD. The mother in Family #1 had symptoms of PTSD in the pretest that were consistent with a diagnosis of partial PTSD. The symptoms had remitted at the time of the posttest and the follow-up.

The behaviour of children is often a symptom of psychological distress. In this study, the CBCL was used to measure the children's internalizing and externalizing behaviours. CBCL data was collected for ten children. The results suggest that in the posttest measurement, the parents of eight of the ten children perceived some improvement in their child's internalizing and externalizing behaviours. This improvement was sustained in the follow-up by three children.

In summary, there was some evidence that symptoms of psychological distress and PTSD decreased for some clients over the course of treatment. Further, the internalizing and externalizing behaviours decreased for several of the children involved in the study. These findings suggest that the treatment approach was effective in reducing symptoms of traumatic stress among individual family members. The fact that the improvement was not sustained in the follow-up for many clients might indicate that the number of treatment sessions was insufficient.

Impact of Treatment on Family Functioning

The second and third objectives of this study focused on family functioning. Unfortunately, conceptual and methodological issues make it difficult to draw conclusions from the findings. These issues will be discussed in the following section.

Methodological Issues

Overall, methodological issues prohibit definitive conclusions about treatment outcome. The most important of these issues will be discussed: the measurement of family functioning, and measurement intervals.

Measurement of Family Functioning. The measurement of family functioning presents perhaps the most serious methodological issue. Family functioning was measured by using self-report measures (i.e., FACES, FES, and the Family Characteristics Scale), a rating scale completed by the clinicians, and the clinical interview. Existing self-report measures of family functioning have been criticized for not being comprehensive in covering the family structures and processes central to family systems theory (L'Abate &

Bagarozzi, 1993). In the study presented in this thesis, an attempt was made to address this criticism by developing a new measure, the Family Characteristics Scale. However, the items in this measure proved to be confusing to the clients, and responses tended to reflect social desirability. As a result, objective measures of some dimensions of family functioning are lacking.

A general issue related to self-report measures is that they are not objective in that they include the values and biases of the people who created them (Gurman, 1983). Further, measures are often designed for, and tested on, particular populations. The extent to which the measures are valid for traumatized families is unknown. The families who participated in this study varied somewhat in respect of socio-economic factors, and one family was of aboriginal ancestry. The extent to which the measures are sensitive to cultural and social-economic factors is also unknown.

A further issue relating to self-report data on family functioning is how to deal with information that is obtained from different members of the same family. In this study, information on family functioning was obtained from both parents in the two-parent families. The results indicate some significant differences in the parents' perceptions of their family. This creates a dilemma when attempting to draw conclusions from the results. The literature debates the merits of combining the information of individual family members to create a composite score (Larsen & Olson, 1990). A composite score could mask the important differences in family members' perceptions, and create an inaccurate "family perspective".

A related issue in interpreting results from self-report measures of family functioning is that the measures provide information on perceptions of family functioning, but the perceptions cannot be assumed to be accurate.

Caution must therefore be exercised in drawing conclusions from self-report data on the family as a functioning system (Ransom et al., 1990).

Another methodological issue relating to the measurement of family functioning is that different measurement procedures often produced inconsistent results. The research literature emphasizes the importance of using a multidimensional approach to collect information on the variables being measured. It further suggests that different types of variables are more sensitive to either subjective or objective data collection procedures and that, ideally, variables should be measured by both methods (Larsen & Olson, 1990). Objective methods (i.e., self-report measures) and subjective methods (clinician's impressions) were used in this study. However, these methods did not always produce consistent results. This again raises the question of the relative merit of subjective information and objective "data".

Despite the weaknesses inherent in self-report measures, they are the predominant method used to measure family functioning. Although this speaks to the lack of alternative measures and the complexity of measuring family functioning, self-report data does provide useful information on one perspective of family functioning.

Measurement Interval. The second methodological issue is the measurement interval. Given that this was a short-term intervention, the time between the pretest and posttest measurements was quite short (i.e, 8 to 12 weeks). The follow-up was also relatively short (i.e., two months), and some families continued in therapy in that interval. The short measurement intervals might limit the degree to which it is possible to detect the full impact of treatment.

Research Implications

Several research implications and recommendations follow from this study. First, the results support the use of case studies to evaluate treatment outcome. Case studies can be conceptualized and carried out in ways that strengthen internal validity (Rabin, 1981; Kazdin, 1982; Penka & Kirk, 1991). The internal validity of this study was strengthened through a pretest, posttest and follow-up research design, the collection of objective data, multidimensional procedures for collecting data, heterogeneous cases, and multiple cases. These features were incorporated into the clinical work with what seemed to the clinicians, to be a minimal amount of intrusion and inconvenience to the families. All this suggests that the case study approach can be an efficient and effective method for evaluating therapeutic interventions.

Second, the results underscore the need to improve the measurement of family functioning. This study, like many others in the field, relied heavily on self-report measures, with which there are serious problems in evaluating the impact of treatment. Self-report data reflect the perceptions of one member of a family, and cannot be interpreted as an accurate description of family processes (Ransom et al., 1990). Further, evidence suggests that responses to at least one of the self-report measures used in this study (i.e., The Family Characteristics Scale) were biased toward social desirability.

A lack of valid and reliable measures of family functioning is an issue that must be addressed by researchers. It is important that the development of new measures not be limited to self-report measures. The validity of research findings are enhanced if more than one measurement procedure is used. It is recommended that future research in this area include a

behavioural observation measure, perhaps in-home behavioural observation with a coding system for recording observations of the various dimensions of family functioning.

A third research implication pertains to the collection of information on the traumatic experiences of family members, and the impact of the experiences on each family member. It would be useful to have descriptive information of each of the traumatic events experienced by family members, and the reactions of each family member to the events. While clinicians typically gather this information in the clinical interview, it would be useful to have a measure, such as perhaps an interview guide, to ensure that comprehensive information on the experience of trauma is obtained in a more structured format than was used in this study.

A fourth research implication relates to the measures of individual functioning. The measures used in this study were the Trauma Sequelae, the BSI, the CBCL and the CSBI. These measures were found to provide important information that was useful to the clinical work and the research. Family therapy often does not provide clinicians with the opportunity to spend much time with individual family members. It was found that the Trauma Sequelae provided information on the parents' experiences of trauma and on symptoms of PTSD that the clinicians did not always obtain through the clinical interview. With respect to the children in the study, one child disclosed suicidal ideations through the CBCL - Youth Self-Report. In another case, the CBCL - Parent Report Form revealed that a child was encopretic. The parents of the children were aware of this, but did not inform the clinicians of it in the clinical interview. This underlines the importance of using self-report measures of individual functioning when intervention focuses on the family.

The final research implication of this study relates to the data collection procedures. The procedures used in this study were effective and relatively efficient. Complete pretest, posttest and follow-up data were obtained from four of the five families. In regard to the fifth family, complete pretest and follow-up data and partial posttest data were obtained. The fact that the family that withdrew from treatment completed the follow-up measures, even though they did not attend their last few treatment sessions, indicates the effectiveness of the data collection procedures. It also speaks to the importance of maintaining a clear separation between treatment and research.

The factor that seemed to contribute most to the effectiveness of the procedures was flexibility. The researchers attempted to accommodate the families as much as possible in regard to where the measures were completed. Some families preferred to complete the measures at the clinic, but most families preferred to complete the measures at home. The researcher accommodated the preferences of the families, and the measures were administered to many of them in their homes.

Conclusion

The results of this study suggest that four of the five families made at least some improvement in areas of individual and family functioning. One family clearly benefited from treatment, and three other families made some progress and agreed to attend further treatment sessions. Only one family withdrew from treatment, and they attended six sessions before doing so. Further, six of the seven adults indicated a high level of satisfaction with the services they received. However, the one client who indicated mild dissatisfaction agreed to attend additional sessions. While it is not possible

to draw firm conclusions about the impact of treatment on all of the families that participated in the study, the results are promising and further study is warranted.

All of the families in the study had experienced long-term chronic trauma, and many of them continued to experience traumatic events over the course of treatment. It therefore could have been unrealistic to assume that short-term treatment could produce significant and lasting change. However, this does not warrant rejecting a short-term treatment approach for traumatized families. Clinicians are well aware of how difficult it can be to sustain a family's motivation for treatment. The short-term nature of the intervention could account, at least in part, for the relatively low attrition rate. It is important to note that the intervention approach is not limited to short-term treatment. In this study, the family's progress is reviewed with them at the end of the treatment phase and, if appropriate, further treatment was recommended. Individual therapy was recommended for some members of one family in the study, and couple therapy was recommended for two other families. The flexibility of the intervention approach is an advantage in working with traumatized families, who often have extensive treatment needs.

Although clinicians are facing increasing demands to demonstrate the efficacy of their services, the lack of valid and reliable measures of family functioning, and the difficulty in carrying out research that that has a high degree of internal validity, discourage clinicians from evaluating their services. However, the pressure on clinicians to be more accountable should not be ignored because it is through evaluating their work that clinicians can obtain the information required to improve interventions, and to improve their ability to assess the type of intervention that could be most

effective for a family. To this end, clinicians and researchers should work together to continue to develop reliable and valid measures of family processes and structures.

This study is an excellent illustration of a collaborative effort by clinicians and researchers. Two teams were involved in the study, a research team and clinical team. As a member of both teams, I functioned as a scientist and a practitioner.

A scientist-practitioner model is an integrative approach in which research and practice continually inform the other. A scientist-practitioner reflects a research orientation in practice and a practice relevance in research. The value of the model was clearly evident in this study. The study evolved from the previous research and clinical experiences of members of the research team. Many of the studies carried out by the team focused on the impact of trauma on the survivor. The results of these studies suggested that family functioning can play an important role in mediating the impact of trauma on the individual. This lead to the hypothesis that family therapy could be an effective intervention for traumatic stress.

The clinical team implemented the treatment approach with the five families in the study, and at times they also served as consultants to the researcher in regard to the implementation of the data collection procedures. Members of the clinical team assisted the researcher to coordinate data gathering procedures with the clinical work, and they demonstrated a high level of cooperation and willingness to have their practice evaluated. A large part of the success of this study can be attributed to their assistance and cooperation.

Future Research Directions

The results of this study suggest that it is important that research efforts continue to explore methods of strengthening the internal validity of the research design, and the validity and reliability of the measures. Recommendations in this regard include using a behavioural observation measure of family functioning, developing a measure to collect information on the traumatic experiences of family members, and lengthening the follow-up. It is also recommended that carrying out further case studies is a viable approach to continuing this exploratory research. The more cases that are involved, the stronger the basis would be for inferring the effects of treatment. Further, with a large number of cases, trends can be identified and explored. For example, it might be that family functioning or the nature of the trauma are predictors of the treatment outcome. However, it will be important for future research to address the problems that were encountered with respect to the measurement of family functioning. It is recommended that future studies rely less on self-report measures and incorporate measures that provide an alternative perspective of the family, such as behavioural observation. Over time, after several case studies have been carried out and the measures and procedures refined, consideration should be given to carrying out a larger scale treatment outcome study, perhaps involving a control or comparison group.

References

Achenbach, T. M. & Edelbrock, C. (1983) Manual for the child behavior checklist and revised child behavior checklist and child behavior profile. Burlington, VT.: Queen City.

American Psychiatric Association (1987) Diagnostic and statistical manual of mental disorders (3rd. ed.). Washington, D.C.: Author.

Barnhill, L. R. (1979) Healthy family systems. The Family Coordinator, 28, 94-100.

Burr, W. R. (1973) Theory construction and the sociology of the family. New York: John Wiley and Sons.

Carter, B. & McGoldrick, M. (Eds.) (1989) The changing family life cycle. A framework for family therapy. Boston: Allyn and Bacon.

Conte, J. R. (1985) The effects of sexual abuse on children: A critique and suggestions for future research. Victimology: An International Journal, 10, 110-130.

Conte, J. & Schuerman, J. (1987) Factors associated with an increased impact of child sexual abuse. Child Abuse and Neglect, 11, 201-211.

Davidson, S. (1980) The clinical effects of massive psychic trauma in families of holocaust survivors. Journal of Marital and Family Therapy, 6, 11-21.

Derogatis, L. R. & Spencer P. (1982) The brief symptom inventory (BSI): Administration, scoring and procedures manual - I. Baltimore, M. D.: Clinical Psychometric Research.

Draper, T. & Marcos, A. (Eds.) (1990) Family variables: Conceptualization, measurement, and use. Newbury Park: Sage Publications.

Edwards, J. & Alexander, P. (1992) The contribution of family background to the long-term adjustment of women sexually abused as children. Journal of Interpersonal Violence, 7, 306-320.

Feinauer, L. (1982) Rape: A family crisis. The American Journal of Family Therapy, 10 (4), 35-39.

Figley, C. R. (1983) Catastrophes: An overview of family reactions. In C. R. Figley and H. I. McCubbin (Eds.) Stress and the family. Volume II: Coping with catastrophe (pp. 3-20). New York: Brunner/Mazel.

Figley, C. R. (Ed.) (1985) Trauma and its wake: The study and treatment of post-traumatic stress disorder. New York: Brunner/Mazel.

Figley, C. R. (1989a) Helping traumatized families. San Francisco: Jossey-Bass Publishers.

Figley, C. R. (Ed.) (1989b) Treating stress in families. New York: Brunner/Mazel.

Figley, C. R. & McCubbin, H. I. (Eds.) (1983) Stress and the family. Volume II: Coping With catastrophe. New York: Brunner/Mazel.

Freyberg, J. T. (1980) Difficulties in separation-individuation as experienced by off-spring of Nazi holocaust survivors. American Journal of Orthopsychiatry, 50, 87-95.

Friedrich, W. N. (1990) Psychotherapy of sexually abused children and their families. New York: W. W. Norton & Company.

Friedrich, W., Beilke, R. & Urquiza, A. (1987) Children from sexually abusive families: A behavioral comparison. Journal of Interpersonal Violence, 2, 391-402.

Friedrich, W., Grambsch, P., Damon, L., Koverola, C., Hewitt, S., Lang, R. & Wolfe, V. (1992) The child sexual behavior inventory: Normative and clinical comparisons. Psychological Assessment, 4(3), 303-311.

Gil, E. (1993) Family Treatment. In E. Gil & T. Cavanagh Johnson, Sexualized children. Assessment and treatment of sexualized children and children who molest (pp. 275-334). Rockville, MD.: Launch Press.

Gurman, A. S. (1983) Famiy therapy research and the "new epistemology". Journal of Marital and Family Therapy, July, 227-234.

Guttman, H. (1991) Systems theory, cybernetics, and epistemology. In A. S. Gurman & D. P. Kniskern (eds.) Handbook of family therapy, Volume II (pp. 41-62). New York: Brunner/Mazel, Publishers.

Hanna, C. (1993) Family functioning and psychological symptomatology in help-seeking and nonhelp-seeking university students. Unpublished master's thesis, University of Manitoba, Winnipeg.

Hanna, C., Koverola, C., Proulx, J. & Battle, P. (Oct. 1992). Psychometric properties of four diagnostic measures for identification of PTSD. Poster presented at the Eighth Annual Meeting of the Society for Traumatic Stress Studies, Los Angeles, California.

Herman, J. L. (1992) Trauma and recovery. New York: BasicBooks.

Hetherington, E. M. (1984) Stress and coping in childen and families. In A. Doyle, D. Gold and D. S. Moskowitz (Eds.) Children in families under stress. San Francisco: Jossey-Bass.

Hill, R. (1949) Families under stress. New York: Harper and Row, Publishers.

Hill, R. (1958) Social stresses on the family. Social Casework, 49, 139-150.

Kazdin, A. E. (1981) Drawing valid inferences from case studies. Journal of Consulting and Clinical Psychology, 49, 183-192.

Kazdin, A. E. (1982) Single-case research designs. N. Y.: Oxford University Press.

Kerr, M. E. (1981) Family systems theory and therapy. In A.S. Gurman & D. P. Kniskern (Eds.) Handbook of family therapy. N.Y.: Brunner/Mazel.

Koverola, C. (1992) The psychological effects of child sexual abuse. In A. H. Heger & S. J. Emans (Eds.) Evaluation of the sexually abused child. N.Y.: Oxford University Press.

Koverola, C. (in press) Post traumatic stress disorder. In H. Ammerman and M. Hersen (Eds.) Handbook of child behaviour therapy in the psychiatric setting. New York: John Wiley and Sons.

Koverola, C. & Battle, P. (in press) Family therapy. In D. Martin and A. Moore (Eds.) First Steps in the Art of Intervention. Pacific Grove, California.

Koverola, C., Proulx, J., Hanna, C., Battle, P. & Chohan, M. (1992) Trauma sequelae: A PTSD questionnaire. Unpublished Manuscript, University of Manitoa.

L'Abate, L. Bagarozzi, D. (1993) Sourcebook of marriage and family evaluation. New York: Brunner/Mazel, Publishers.

Lanz, J. & Lanz, J. (1991) Franklian treatment with the traumatized family. Journal of Family Psychotherapy, 2, 61-73.

Larsen, A. & Olson, D. H. (1990) Capturing the complexity of family systems: Integrating family theory, family scores, and family analysis. In T. Draper & A. Marcos (Eds.) Family variables: Conceptualization, measurement, and use (pp. 19-47). Newbury Park: Sage Publications.

Maloney, L. J. (1988) Post traumatic stresses on women partners of vietnam veterans. Smith College Studies in Social Work, 58, 122-143.

Marcos, A. & Draper T. (1990) Capturing family variables. In T. Draper & A. Marcos (Eds.) Family variables: Conceptualization, measurement, and use (pp. 13-18). Newbury Park: Sage Publications.

McCubbin, H. I., Constance, B. J., Cauble, A. E., Comeau, J. K., Patterson, J. M. & Needle, R. H. (1980) Family stress and coping: A decade review. Journal of Marriage and the Family, 43(4), 855-872.

McCubbin, H. I. & Figley, C. R. (1983a) Bridging normative and catastrophic family stress. In H. I. McCubbin & C. R. Figley (Eds.) Stress and the family. Volume 1: Coping with normative transitions (pp. xix-xxvi). New York: Brunner/Mazel, Publishers.

McCubbin, H. I. & Figley, C. R. (Eds.) (1983b) Stress and the family. Volume I: Coping with normative transitions. New York: Brunner/Mazel, Publishers.

McCubbin, M. A. & McCubbin, H. I. (1989) Theoretical orientations to family stress and coping. In C. R. Figley (Ed.) Treating stress in families (pp. 3-43). New York:Brunner/Mazel, Publishers.

McCubbin, H. I. & Patterson, J. M. (1983) Family transitions: Adaptations to stress. In H. I. McCubbin & C. R. Figley (Eds.) Stress and the family. Volume I: Coping with normative transitions (pp. 5-25). New York: Brunner/Mazel, Publishers.

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

McGoldrick, M. & Walsh, F. (1991) A time to mourn: Death and the family life cycle. In F. Walsh & M. McGoldrick (Eds.) Living beyond loss. Death in the family (pp. 30-49). New York: W. W. Norton & Company.

McIntyre, J. E. (1993) Secondary traumatization in parents following child disclosures of extrafamilial sexual abuse. Unpublished doctoral dissertation, University of Ottawa, Ottawa, Ontario.

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

Moos, R. H. and Moos, B. S. (1986) Family environment scale manual. Second edition. Palo Alto, California: Consulting Psychologists Press, Inc.

Nichols, W. C. (1989) A family systems approach. In C. R. Figley (Ed.) Treating stress in families (pp. 67-96). New York: Brunner/Mazel, Publishers.

O'Hare, T. (1991) Integrating research and practice: A framework for implementation. Social Work, 36, 220-223.

Olson, D. H. (1986) Circumplex model VII: Validation studies and FACES III. Family Process, 25, 337-351.

Olson, D., Porter, J. & Lavee, Y. (1985) FACES III. St. Paul, Minnesota: Universota of Minesota, Family Social Science.

Olson, D. H., Sprenkle, D. H. & Russell, C. S. (1979) Circumplex model of marital and family systems: I. Cohesion and adaptability dimensions, Family types, and clinical applications. Family Process, 18, 3-28.

Pelletier, G. & Handy, L. C. (1986) Family dysfunction and the psycholgocial impact of child sexual abuse. Canadian Journal of Psychiatry, 31(5), 407-412.

Penka, C. E. & Kirk, S. A. (1991) Practitioner involvement in clinical evaluation. Social Work, 36, 513-517.

Rabin, C. (1981) The single-case design in family therapy evaluation research. Family Process, 20, 351-366.

Ransom, D., Fisher, L., Phillips, S., Kokes, R., & Weiss, R. (1990) The logic of measurement in family research. In T. Draper & A. Marcos (Eds.) Family variables: Conceptualization, measurement, and use (pp. 48-63). Newbury Park: Sage Publications.

Ray, K., Jackson, J., & Townsley, R. (1991) Family environments of victoms of intrafamilial and extrafamilial child sexual abuse. Journal of Family Violence, 6, 365-374.

Rosenheck, R. & Nathan, P. (1985) Secondary traumatization in children of vietnam veterans. Hospital and Community Psychiatry, 36 (5), 538-539).

Ross, A. O. (1981) Of rigor and relevance. Professional Psychology, 12, 318-327.

Sayger, T. (1992) Family psychology and therapy. In C. E. Walker & M. C. Roberts (Eds.) Handbook of clinical child psychology (pp. 783-807). New York: John Wiley & Sons.

Solomon, Z., Waysman, M., Levy, G., Fried, B., Mikulincer, M., Benbenishty, R., Florian, V., Bleich, A. (1992) From front line to home front: A study of secondary traumatization. Family Process, 31, 289-302.

Walsh, F. (Ed.) (1982) Normal family processes. New York: The Guilford Press.

Walsh, F. & McGoldrick, M (Eds.) (1991) Living beyond loss. Death in the family. New York: W. W. Norton & Company.

Wolfe, D. (1987) Child abuse. Implications for child development and psychopathology. Vol. 10. Developmental clinical psychology and psychiatry. Newbury Park, California: Sage Publications.

Appendix A

Family Characteristics Scale

Please circle the number which corresponds most closely to how you would describe your family (the family you live with now):

1. In some families, differences between family members are viewed negatively. In other families, family members are encouraged to develop independence of thought, feeling and action.

   In your family, are family members usually:

Encouraged to be independent from each other.	1.....2.....3.....4.....5.....6.....7	Discouraged from being independent.

2. In some families, family members experience a sense of intimacy, and closeness with each other. In other families, family members feel distant or separate from other members.

   In your family, do you usually feel emotionally:

Distant from most other members.	1.....2.....3.....4.....5.....6.....7	Close to most other members.

3. Some families respond easily to changes in the family, such as the changing needs of the children. Other families have more difficulty adapting to this type of change.

   How well does your family deal with change:

Very well	1.....2.....3.....4.....5.....6.....7	Very poorly

4. Some families can be described as organized, predictable and consistent. Other families can be described as disorganized, spontaneous, and inconsistent.

   Would you describe your family as primarily:

Unorganized	1.....2.....3.....4.....5.....6.....7	Highly organized

5. In some families, family members tend to view shared events in the same way. In other families, family members tend to view these events quite differently.

   Do members of your family tend to:

See things the same way.	1.....2.....3.....4.....5.....6.....7	See things differently.

6. In some families, family members communicate directly and openly with each other. In other families communication is indirect, unclear and confusing.

   In your family, is communication:

Open and direct.	1.....2.....3.....4.....5.....6.....7	Indirect or unclear.

7. In some families there are clearly defined tasks and functions for which family members are responsible. These roles are usually complementary such that all the necessary tasks of the family are taken care of by someone in the family.

   In your family, do family members have:

Clearly defined roles roles.	1.....2.....3.....4.....5.....6.....7	Not clearly defined

8. In some families there is a clear division between the generations, that is, between the parents and the children. This means that usually the parents stick together, and children stick together. In other families generational boundaries are less clear. For example a parent may be closer to a child than to the other parent. In the case of a single parent family, the parent may treat a child more like an adult than a child.

   If you are a **two parent family**, do you as parents generally:

Stick together on most decisions	1.....2.....3.....4.....5.....6.....7	One parent sides with a child(ren).

   If you are a **single parent family**, do you:

Make most of the decisions independently.	1.....2.....3.....4.....5.....6.....7	Involve the child(ren) in decision making.

Appendix B

Trauma Sequelae

People sometimes have life experiences that are extremely stressful and disturbing. We are interested in knowing more about how these experiences affect people. Examples of the types of experiences we are studying are:

(a) being involved in a disaster such as a plane crash, fire, or flood;

(b) experiencing a serious threat to our life or health, such as sexual or physical abuse or assault, having a life-threatening operation, or being seriously injured in an accident;

(c) experiencing a serious threat to the life or health of someone close to you (e.g., kidnapping, suicide);

(d) seeing another person who was seriously injured or dead.

If you have had any of these kinds of experiences during your life, please list each experience below, give a brief description, and give your age at the time of the experience.

	Experience	Age
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

If you listed more than one experience, please answer the following questions with regard to the experience you found **most traumatic**, and **circle the number of the experience in the list above.**

1. Do you have recurring memories of the experience?

   Yes ___ No ___

2. Do memories of the experience intrude on your life?

   Yes ___ No ___

3. Do these memories distress you?

   Yes ___ No ___

4. Do you have recurrent dreams about the experience?

   Yes ___ No ___

   If yes, are these dreams upsetting?

   Yes ___ No ___

5. Have you had a sense of reliving the experience?
   (For example, have you acted or felt as though the experience were recurring? Include any experiences that happened upon awakening or when intoxicated.)

   Yes ___ No ___

6. Have you experienced flashbacks (e.g.: replaying of vivid memories of the experience)?

   Yes ___ No ___

7. Have you experienced perceptual illusions (i.e. mistaken perceptions; for example, you thought you saw your abuser on the street, but it couldn't have been him/her)?

   Yes ___ No ___

8. Have you experienced hallucinations (i.e. hearing or seeing things that aren't there)?

   Yes ___ No ___

9. Do you feel distressed or upset when you are reminded of the experience? (For example, does the anniversary of the experience upset you?)

   Yes ___ No ___

10. Do you have any other symbolic reminders of the experience? (e.g. objects, music, words or phrases which trigger memories of the experience?)

    Yes ___ No ___

In reference to questions 1 to 10, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the experience did they begin to occur?

less than 6 months ___ more than 6 months ___

11. Do you deliberately avoid thoughts or feelings that remind you of the experience?

    Yes ___ No ___

12. Do you deliberately avoid activities or situations that remind you of the experience?

    Yes ___ No ___

13. Do you find that you have trouble remembering certain aspects of the experience?

    Yes ___ No ___

14. Are you much less interested in things that used to be important to you (e.g. sports, hobbies, social activities)?

    Yes ___ No ___

15. Do you feel distant or cut off from others?

    Yes ___ No ___

16. Do you feel emotionally numb? (For example, are you no longer to feel strongly about things or have loving feelings for people?)

    Yes ___ No ___

17. Do you feel pessimistic about your future?

    Yes ___ No ___

In reference to questions 11 to 17, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the experience did they begin to occur?

less than 6 months ___ more than 6 months ___

18. Do you have trouble sleeping?

    Yes ___ No ___

19. Are you often irritable, or do you often have outbursts of anger?

    Yes ___ No ___

20. Do you have trouble concentrating?

    Yes ___ No ___

21. Are you watchful or on guard even when there is no reason to be?

    Yes ___ No ___

22. Do you find yourself reacting physically to things that remind you of the experience?

    Yes ___ No ___

23. Do you startle easily?

Yes ___ No ___

In reference to questions 18 to 23, please answer the following:

(a) How long have any of the above been occurring?

less than 1 month ___ more than 1 month ___

(b) How soon after the experience did they begin to occur?

less than 6 months ___ more than 6 months ___

Note: Printed in its entirety in Family Functioning and Psychological Symptomatology in Help-seeking and Nonhelp-seeking University Students, by Cindy Hanna, 1993, unpublished Master's thesis, University of Manitoba, Winnipeg.

Appendix C

Child Sexual Behaviour Inventory

Child's age in years _____

Child's sex (check one): ___ male

___ female

Please circle the number that tells how often your child has shown the following behaviors **recently or in the last 6 months**:

Never	Less than 1/month	1-3 times/month	At least 1/week
0	1	2	3

0	1	2	3	Plays with dolls with adult sex parts.
0	1	2	3	Sees nude adults.
0	1	2	3	Showers or bathes with an adult.
0	1	2	3	Dresses like the opposite sex.
0	1	2	3	Talks about wanting to be the opposite sex.
0	1	2	3	Touches sex (private) parts when in public places.
0	1	2	3	Masturbates with hand.
0	1	2	3	Does not want to undress in front of others.
0	1	2	3	Scratches anal and/or crotch area.
0	1	2	3	Touches or tries to touch their mother's or other women's breasts.
0	1	2	3	Masturbates with object.
0	1	2	3	Touches other peoples' sex (private) parts.
0	1	2	3	Imitates the act of sexual intercourse.
0	1	2	3	Asks parent(s) to stop showing sexually related activity (necking, fondling, etc.)
0	1	2	3	Puts mouth on another child/adult's sex parts.

0	1	2	3	Touches sex (private) parts when at home.
0	1	2	3	Uses words that describe sex acts.
0	1	2	3	Pretends to be the opposite sex when playing.
0	1	2	3	Watches parent(s) show sexual behavior such as necking, or fondling.
0	1	2	3	Makes sexual sounds (signing, moaning, heavy breathing, etc.)
0	1	2	3	Asks parent(s) to stop showing affectionate behavior such as hugging or kissing.
0	1	2	3	Asks others to engage in sexual acts with him or her.
0	1	2	3	Rubs body against people or furniture.
0	1	2	3	Inserts or tries to insert objects in vagina/anus.
0	1	2	3	Tries to look at people when they are nude or undressing.
0	1	2	3	Imitates sexual behavior with dolls or stuffed animals.
0	1	2	3	Watches parent(s) show affectionate behavior (hugging, kissing, etc.)
0	1	2	3	Constipated.
0	1	2	3	Shows sex (private) parts to adults.
0	1	2	3	Tries to view pictures of nude or partially dressed people (may not include catalogs).
0	1	2	3	Talks about sexual acts.
0	1	2	3	Urinates outside of the toilet.
0	1	2	3	Delays bowel movements as long as possible.
0	1	2	3	Delays urinating.
0	1	2	3	Kisses adults not in the family.
0	1	2	3	Undresses self in front of others.
0	1	2	3	Sits with crotch or underwear exposed.
0	1	2	3	Kisses other children not in the family.

0 1 2 3 Talks in a flirtatious manner.

0 1 2 3 Tries to undress other children or adults against their will (opening pants, shirt, etc.)

0 1 2 3 Asks to view nude or sexually explicit TV shows (may include video movies or HBO type shows).

0 1 2 3 When kissing, tries to put tongue in other person's mouth.

0 1 2 3 Hugs adults he or she does not know well.

0 1 2 3 Shows sex (private) parts to children)

0 1 2 3 If a girl, overly aggressive; if a boy, overly passive.

0 1 2 3 Seems very interested in the opposite sex.

0 1 2 3 Will get physically sick when feeling upset or sad.

0 1 2 3 If a boy, plays with girl's toys; if a girl, plays with boy's toys.

0 1 2 3 Other sexual behaviors (please describe)

A. _____

B. _____

Has any critical event occurred to your child in the past month, e.g. death of relative, hospitalization, abuse, parental separation, etc.?

____ Yes ____ No

If yes, please describe

_____

_____

_____

Note: Printed in its entirety in Psychotherapy of Sexually Abused Children and Their Families, by W. N. Friedrich, 1990, New York: W. W. Norton & Company.

Appendix D

Client Satisfaction Questionnaire

Please help us improve our program by answering these questions. We are interested in your honest opinion, whether it is positive or negative. We also welcome your comments and suggestions. Thank you very much. We really appreciate your help.

Please circle your answer:

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

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

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

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

3. Additional Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Appendix E

Telephone Screening Interview

This is (name) calling from the Community Resource Clinic. I'm calling
-- in response to your call here seeking services or
-- I'm calling because you were referred here by ___.

Can I ask you to tell me a little about what you and your family would like help with?

(Explore the nature of traumatic event and the impact it has had on family members.)

[Determine whether one or more members of the family have experienced a traumatic event, such as abuse, violence, death, car accident, separation and divorce, chronic illness.]

If the following information have not become evident from the above, probe the following areas:

- **Composition of family:** number and age of children, relationship of primary caregiver to children (eg. foster parents), does the perpetrator live in the home.
- **Involvement in Court Proceedings:** Specific questions to determine whether family members are involved in court proceedings (eg. custody cases, criminal charges related to child sexual abuse), and whether there is a history of child sexual abuse in the family.
- **Child and Family Services Involvement:** Specific questions to determine whether Child and Family Services is involved with this family and the nature of that involvement. (To determine whether there is an abuse investigation underway.)

- **Substance Abuse:** Specific questions related to substance abuse, such as:

  Some people, when they are faced with such a stressful situation, turn to alcohol or drugs to help them cope. Is this the case for you (or your wife/husband)?

- <u>If a family meets the elibility criteria for the research study:</u>

  The research assistant will state:

  The Community Resource Clinic is a training facility for clinical psychology and social work students from the University of Manitoba. We also conduct research on the services we provide to clients. Dr. Koverola, one of our psychologists, has a treatment program for families that you would be eligible to participate in. This treatment program involves an assessment phase, a treatment phase, and a follow-up phase. You would come in for a 2 hour session the first time, on a Monday or Tuesday morning. You will be meeting with the research assistant to fill out some questionnaires, and you will have intake interview. The whole family is required to come. After the first session, there is some flexibility as to when you come in. You will also be required to complete questionnaires at the completion of treatment, and about 2 months later.

  There will be a team of clinicians working with you and your family. Because we work as a team, the program is intensive and short term. The assessment phase involves 3 sessions and the treatment phase will involve 5 sessions. The need for ongoing services after this point will be re-evaluated at that time.

If the family consents to participate in the research, an intake session is scheduled.

- <u>If the family does not consent to participate, or if they do not meet the eligibility criteria for the research, but they meet the criteria for CRC</u> (i.e. the family has no court proceedings pending):

  The research assistant will state:

  Thank you very much for taking the time to provide me with information about the problem your family would like help with. At this time we have a waiting list for services, and your name will be placed on this list. You can expect to hear from someone in approximately _____.

- If the family does not meet the criteria for the research study or for receiving services at the CRC:

  The research assistant will state:

  As you know, CRC is a training facility for students. Because of that, we are not able to take on cases that are involved with the courts. I would be willing to assist you to find services elsewhere, if you wish.

If they request assistance finding services, explore which agencies they have contacted already. Use CRC standard referral procedures.

Appendix F

Consent Form

To be more helpful to families who have experienced stress or trauma, we are conducting a study to learn more about the effects of these experiences on families. Our goal is to develop a model for assessing and treating families who have experienced trauma.

This study is being directed by Dr. Catherine Koverola of the Department of Psychology, University of Manitoba. Families who participate in this study will receive family assessment and family therapy from graduate student therapists in clinical psychology and social work, under the supervision of Dr. Koverola.

Your family's participation in this research project will mean that you will complete 3 sets of questionnaires -- one at the beginning of therapy, one at the end of therapy, and one about 2 months after therapy. It will take you about 2 hours each time to complete the questionnaires, and this may be done over 2 sittings. All information gathered will be confidential. All family therapy sessions will be videotaped. These videotapes will be used only for supervision of the therapists, and they will be kept strictly confidential.

Your participation in the study is fully voluntary. You are free to withdraw from the study at any time.

I have been informed and agree to participate in this research study.

_____	_____
Witness	Signature
_____	_____
Witness	Signature
	_____
	Date

I have discussed the nature of the research study with my child(ren) and believe that she/he (they) has/have understood and is participating voluntarily.

Witness	Name of Child	Signature of Parent/Guardian
Witness	Name of Child	Signature of Parent/Guardian
	Name of Child	
	Name of Child	
	Name of Child	

Appendix G

Letters of Permission

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Appendix H

Trauma Sequelae Scoring Criteria

Criteria A: The person must have experienced a traumatic event outside the range of normal human functioning.

Criteria B: Re-experiencing the trauma. The person must answer yes to at least one of the questions 1-10, and the duration of these symptoms must be at least one month.

Criteria C: Avoidance of stimuli associated with the trauma. The person must answer yes to at least three of questions 11 -17, and the duration of these symptoms must be at least one month.

Criteria D: Increased arousal. The person must answer yes to at least two of questions 18-23, and the duration of these symptoms must be at least one month.

Criteria A, B, C, and D are necessary to categorize the person as PTSD positive. Partial PTSD is indicated when the person meets Criterion A plus any two of B, C, or D.