THE UNADJUSTED ADOLESCENT GIRL AND HER FAMILY

A Practicum Report

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THE UNADJUSTED ADOLESCENT GIRL AND HER FAMILY

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Practicum

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INTRODUCTION

A. OBJECTIVES OF THE PRACTICUM

The objectives of the practicum experience were as follows:

1) To develop clinical family therapy skills;

2) To develop the skills to conduct individual psychotherapy;

3) To explore the literature on family therapy and adolescence as it applies to adolescent females and their families.

B. THE PRACTICUM REPORT

The practicum report will discuss the student's experience in the areas outlined above. In the first chapter this report will consider the literature on adolescents and families with a focus on the developmental tasks, issues and themes of adolescence. Female adolescents will be looked at closely. The literature review will also cover the adaptation of the family to an adolescent family member attempting to master, successfully, the developmental tasks of adolescence. This discussion of the family will address the role that the family has in socializing adolescents both in western society and in other cultures, the changes a family containing an adolescent go through and the appropriateness and timeliness of family-based interventions. Some of the themes present in the literature on family therapy will be discussed.

The second chapter of the report will describe the setting of the practicum and will discuss some of the cases that were carried out by the student. Each case discussion will describe the interventive approach and theoretical base that were utilized. This will be done for both the family therapy cases and the one individual psychotherapy case.

The third chapter will highlight one of the case examples discussed in Chapter 2. In this chapter the effects that treatment had on the family will be discussed.

The fourth and concluding chapter will be in two parts. First, there will be a brief discussion of three common issues that arose in all of the families. These issues pose therapeutic challenges for anyone working with families containing adolescents. The chapter will end discussing the practicum as a whole and the areas in which the student learned skills and gained knowledge.

CHAPTER 1

THE LITERATURE REVIEW

A) DEVELOPMENTAL THEMES. ISSUES AND TASKS OF ADOLESCENCE

Adolescence is the stage of development that one is in between the ages of 11 - 19 years (Thornberg 1975 p. 5). Within the stage of adolescence are three substages: early, middle and late adolescence, each characterized by certain behaviors.

The literature on adolescence seems to divided on the issue of whether adolescence is typically a time of upheaval and turmoil or whether the turmoil is a myth, and that adolescence is a stage where most pass through with little difficulty and little "storm and stress".

The traditional view of adolescence - that is the "storm and stress" view was advanced initially by Hall in 1928. Oldham 1980 (p. 271 - 272) states that this belief was supported by subsequent psychoanaltyic interpretations (Freud 1958, Jones 1922, Aichorn 1935, Bernfield 1938, Blos 1962, Geleerd 1957, and Lindermann 1964.) In fact, Lindermann states that a calm adolescence is indicative of a developmental disturbance and cause for problems at a later time (Lindermann 1964).

The more recent research in adolescence shifts from the traditional by focusing on normative data from large samples of teenagers, rather than a small sample made up of psychiatric patients. Oldham (1980) has researched the recent studies and cities the Douvan and Adelson study of the middle 1950's. They concluded that normative teenagers experience little of the acting out or turbulence. They reinforce the belief that teenage years are characteristized by passion, restlessness, and conflict. (Oldham 1980, P. 273)

Oldham synthesized the more recent research on adolescent turmoil in the following way:

> "Adolescents normatively maintain psychic equilibrium as they struggle with developmental tasks,
> - Adolescent development is normatively associated with successful social and family adjustment which persists into early adulthood,
> - Adolescent turmoil is normatively manifested in mild forms of depression and anxiety and in minor disagreements with authority figures,
> - Symptoms other than mild depression and anxiety often are indicative of psychiatric illness and may warrant professional attention,
> - Adolescent symptom patterns tend to persist and become better differentiated over time,
> - Adolescent "turmoil" is distinguishable from psychiatric illness but may intensify concurrent disorders,
> - Difficulties in differential diagnosis during adolescence have more to do with obscurities inherent in the psychiatric diagnoses themselves than with the presence of absence of "turmoil"." (p. 277 - 8)

Other writers (Conger 1979, Mitchell 1975, Bandura 1969) posit views similar to those of Oldham. Conger states that the stresses of adolescence do not produce the high degree of turmoil and threatened loss of control. He believes, however, that these behaviors are seen only in a limited population. Mitchell believes that adolescents have been misunderstood by the traditional theorists who directed their attention to early adolescents and didn't take into account the contributions that adolescents make. Bandura believes that the stresses of adolescence are largely products of difficulties begun in pre-adolescent social experiences. He further believes that the parent-child conflict is not intense due to the fact that by adolescence most boys (Bandura's study was with adolescent males) have internalized their parents' values and standards.

Thus, the current research leans heavily to the belief that adolescence is not typically a period of storm and stress, but a period of learning, growth and identity development without the turmoil.

Before one successfully leaves adolescence, that person must adequately deal with several developmental themes, issues and tasks. Some of the most salient of the issues will be discussed in this section of the literature review.

Eric Erikson (1968) identifies as a major task of adolescence the development of identity. Erikson believes that without this sense of identity, an individual is incapable of the development of true intimacy in his adult life, (Mitchell 1975, p. 19).

Erikson (1950; 1963) labelled this developmental task of adolescence as "Identity VS Role Confusion". Erikson sees this as a normative crisis, and believes that the turmoil that results is from the role diffusion that accompanies the normal adolescent crisis.

Erikson (1963) states the following:

> "The growing and developing youths faced with this psychological revolution within them, and with tangible adult tasks ahead of them are now primarily concerned with what they appear to be in the eyes of others as compared with what they feel they are, and with the question of how to connect the roles and skills cultivated earlier with the occupational prototypes of the day." (p. 261)

The adolescent tries to develop an identity for himself and is searching for the social values which guide that identity. (Erikson 1963)

Erikson's stage has been broken down into the following themes:

a) Development of one's own system of authority and control;

b) Development of an adequate adult role;

c) Role experimentation and the use of the peer group;

d) Development of a sexual identity;

e) Development of life goals - "What am I going to do to be successful?"

All of these themes aid in the development of a sense of identity.

a) DEVELOPMENT OF ONE'S OWN SYSTEM OF AUTHORITY AND CONTROL

This issues of authority and control are important ones for most adolescents. Adolescents tend to believe that they are sufficiently mature and capable of determining their own limits and controls. Thus they resent any controls that may be imposed upon them (in what always seems to be an arbitrary way) by parents, teachers or any adults with authority. (This has been viewed and experienced by the writer over and over again in the adolescents that have been involved in treatment.) Unless the adolescent learns to determine appropriate self controls, he/she will be unable to set appropriate self limits because there wasn't an adequate period of trial and error.

The literature deals with the process whereby the adolescent becomes autonomous from parents as a way to begin to set his own controls.

Mitchell (1975) believes that at the core of adolescence is the impulse to assert oneself. He states that the adolescent has a great need to express and assert himself due to more self-awareness, but that is is impossible to do this in any meaningful way.

Conger (1977) believes that the development of independence in central to all of the adolescent tasks. He further believes that if an adolescent does not separate and become autonomous from parents, he can't be expected to achieve mature relationships, a career or vocation, or a sense of identity.

Thornburg (1975) believes that an adolescent tests out family values during his teen years in an attempt to develop the personal set of values needed to accept him as an individual. He states that the adolescent seeks behavioral autonomy from parents in regards to dating, employment, economic resources and choice of friends. Emotional autonomy develops as the adolescent learns self-control and self-reliance. Thornburg also points out

adolescents achieve autonomy in different ways. Some become very distant from their parents in a short period of time, other do this gradually, and some not at all. However, all adolescents do have desires for autonomy.

Josselyn (1975) points out that the adolescent may be ambivalent about controls. Her belief is that the adolescent needs some form of controls placed upon him in order to feel safe. Within these safe limits, the adolescent can then feel more comfortable in exploring areas that are within these limits. This will allow the adolescent to experiement with his strong impulse to be independent.

Gisela Konopka (1966) also discusses the idea of controls, limits and authority. Her discussion addresses delinquent females and their perceptions of authority. Konopka points out that these adolescents tend to meet adults in the form of authority figures only, and don't receive the opposite side of controls - the love that is given in more typical families. Because of poverty and social degradation, the parents of most of the girls that Konopka worked with were unable to parent adequately due to their inability to manage their own lives. These girls felt only mistrust for authority figures. The social workers working with them received the brunt of their distrust and anger.

Konopka (1966) states the following:

> "What they need is a person who respects them and whom they can respect, a person who can laugh with them but who does not laugh at them. Behind the hatred and misunderstanding lies much of their own incapacity to understand themselves and their hopelessness." (p. 61)

It is this blend of respect and caring that adolescents require of those adults who establish and set limits and controls.

The literature explored in this area is consistent in its position that becoming autonomous from parents and developing one's own set of limits and controls is an essential adolescent task.

b) DEVELOPMENT OF AN ADEQUATE ADULT ROLE

The developmental phase of adolescence prepares one for "the taking on" of the adult role. Adolescents need to practice an adult role in order that when they become adults some firm values and beliefs have been established.

Elder (1968), referring to adolescent socialization, states that the process of developing an adult role begins in high school where there is an increase in peer involvement and an assertion of independence from the family. Abstract reasoning begins, and the adolescent starts to make decisions about the anticipated future. Learning the adult role requires learning about the relationships an adult forms. The relevance of learning and experience in other situations and how easily this learning is generalized determines how quickly an adolescent is able to take on the adult role.

Lynn (1969) studied the adolescent identification process and the method whereby adolescents learn parental and sex-role identification. He hypothesises:

> "Males tend to identify with a culturally defined masculine role whereas females tend to identify with their mothers". (p. 100)

Lynn believes that boys identify with the cultural role due to the fact that father is seldom seen during the course of the day while he works, and thus the son has few details on which he can model. Both boys and girls spend all day observing mother, and girls have a detailed view of adult female life and are able to model after mother. The conventional masculine role is often made clear to boys through his mother and teachers and her therefore identifies with that model.

This writer questions the relevance of Lynn's work today. This study may not be an accurate reflection of family life in the 1980's. With an

increasing number of mothers returning to the labour force while their children are still small, mothers may not be able to provide sex role modelling consistent with Lynn's hypothesis.

Conger (1977) deals with the type of parent-child interaction that is needed to prepare the adolescent to cope with the adult world. He cites two major dimensions of parental behavior that have an influence on adolescent adjustment. The first of these is love-hostility and the second is autonomy-control. The combination of those two dimensions produces a variety in the behavior of children. Baumrind (1975) supports this view.

Thornburg (1975) stated that the family is the initial locus of the child's social learning. At adolescence this locus is shifted to the peer group. He also states that the adolescent process of becoming socialized as an adult is characterized by the identification of one's social role with a minimum of value-behavior discrepancies.

Thus the literature states that the adolescent socialization process begins in childhood and continues on through the teen years with peer interaction, and then crystalizes with the development of one's own social role.

c) ROLE EXPERIMENTATION

Another way in which the adolescent develops an identity is through role experimentation. Adolescents try on a variety of roles, as if these roles were hats, in an attempt to determine which hat fits most comfortably.

These roles vary greatly. Some adolescents experiment with drugs, others with sex, some want to work in an attempt to be mature, and others want simply to do nothing. As all adolescents varies in personality, so do the roles with which they experiment. Role experimentation clearly happens in the peer group.

Eisenberg (1965) notes that the adolescent search for identity is greatly influenced by the peer group. If the peer group is constructive and provides positive outlets for adolescents energy and creativity, then positive role experimentation takes place. If, on the other hand, the peer group has a delinquent value system, then the role experimentation that takes place tends to be anti-social. This can have devastaging effects if the police and the juvenile justice system become involved in that it could lead to the adolescent's becoming labelled "delinquent".

Mitchell (1975) dealt extensively with role experimentation. His belief is that the adolescent must experiment with various social roles and patterns to test out the different aspects of his personality. Mitchell states that the childhood identities no longer fit during adolescence, and that the only way a new identity can be formed is through sampling and experimenting:

> "Identity demands experimentation and sampling and adolescence is the time of life when a good deal of it takes place." (p. 53)

Mitchell also points out that the adolescents strong needs for status, acceptance and independence are only satisfied through the trying on of different roles. Recognizing one's place in the peer group comes about after much testing. Mitchell believes that role experimentation is

particularly important in four general areas:

Gender roles
Competence roles
Social roles
Independence roles.

Gender roles are the patterns of behavior which suit the adolescent's concept of appropriate sex behavior. Competence roles are the exercise of skills the adolescent is attempting to master. Social roles are the patterns of interaction which allow the individual to find out how it feels to express various aspects of his own personality. Independence roles are the patterns of behaviour in which the individual decides for himself what he shall do, realizing that there may be consequences for his behaivor.

Drug and alcohol use are one way adolescents experiment. Levine (1977) discusses the reasons for drug use and divides these reasons into two major areas - social factors and personal factors. The social factors he describes are pressures of living in contemporary society and within a cultural ethic. Drug use can provide a temporary relief from some of the pressures felt. The personal factors are intellectual, curiosity, recreation, ignorance, philosophy, ritual, self-awareness, rebellion, escape and compulsive self-destruction. These factors account for the adolescent's wanting to participate in a new experience (intellectual curiousity), to acting out feelings of resentment, to the society as a whole (rebellion). It is Levine's belief that the majority of adolescents who use drugs, use minor substances (marijuana) and suffer no ill effects. Drug abuse is symptomatic of other problems.

Conger (1977) agrees with Levine's premise as to why adolescents take drugs. He states that it may be rebellion or curiosity. For some, the cause of their drug-taking is a rejection of the values of the adult society. Heavy drug users, or drug abusers, he states, may be emotionally disturbed or unable to find a meaningful personal identity.

Conger views adolescent alcohol use in a similar way. The cause of this is often curiosity, identification with parental models who drink, or a desire to appear grown up. The effects of alcohol itself are very reinforcing (the high, the reduction of anxiety) and this often leads to further drinking.

Thornburg (1975) cites research that states that the single most accurate tool for predicting an adolescent's drinking behavior is his knowledge of his parents' drinking behavior. Reinforcement for drinking by peers also plays a prime role in predicting drinking behavior. Thornburg suggests that the reinforcing effects of alcohol stem from the relief it provides to all types of anxiety. Thus the person will drink to avoid unpleasant feelings.

The peer group is the area where most role experimentation takes place. Mitchell (1975) states that an adolescent cannot grow without peer involvement. The adolescent need for recognition is gratified when peers acknowledge one's presence and their importance. The adolescent, Mitchell believes, has a great need to belong and peer group acceptance is a primary way of satisfying this need.

During middle and late adolescence, the adolescent searches out groups who have beliefs and viewpoints in common. He becomes more selective as his needs of belonging are satisfied. Mitchell states that because the adolescent is dependent upon his peers for his need gratification, he has to be very careful not to alienate them. All adolescents continually rate and evaluate each other.

> "Adolescent self esteem is primarily gratified when outsiders indicate to the person that he is respected, thought well of, admired, or held in high regard. (Mitchell 1977, p. 150)

Conger (1977) suggests that one of the reasons that peers have such a prominent role in adolescence is because relationships with same sex and

opposite sex peers serve as prototypes for later adult relationships. The person who hasn't learned how to get along with others of the same sex or how to extablish a satisfactory heterosexual relationship may have difficulty in later years.

Conger states another important aspect of adolescent peer relationships:

> "As Peter Blos, Anna Freud and others have observed, adolescence may provide an important opportunity sometimes the last major opportunity, for repairing psychological damage incurred during the years of early and middle childhood and for developing new and more rewarding relationships with one's self and with others. A mature, warm interested, and above all, non-exploitative adolescent peer may play an important, sometimes crucial, role in helping a boy or girl to gain a clearer concept of self, problems and goals; a feeling of personal worth and renewed hope for the future." (p. 326)

Josselyn (1971) has suggested that,

> "One of the major tasks of the adolescent is to structure a value system which will satisfy his own self image and provide a pattern of adaptation to the demands of the external world". (p. 148)

Role experimentation is one of the routes that the adolescent takes in order to achieve value and identify tasks. The role of the peer group helps the adolescent to define his sense of identity, which is quite fluid during adolescence. Role experimentation within the peer group provides the adolescent with an opportunity to test identity and gain some sense of self.

d) DEVELOPMENT OF A SEXUAL IDENTITY

With the development of secondary sex characteristics and the physical maturation of the body, it is very natural that the adolescent begin to develop a sexual identity (Conger, 1977). The new sexual identity is developed in many ways. The adolescent learns the appropriate roles of male and female, and may experiment sexually to learn what this new body does. The adolescent asks what it means to be an adult of his/her sex.

The prevalence of sex related literature, movies, television shows and advertising serves to entice the adolescent into sexual behavior. The adolescent is often urged into a sexual relationship prior to being able to emotionally understand the complications and consequences of such a relationship.

Woodring (1968) talks of the change in attitude towards sexual behaviors:

> "Some of the books read by teenagers today still frown upon 'heavy petting' and give advice against premarital intercourse, but the reasons given usually are practical or psychological rather than ethical. Most of the authors agree that a modest degree of petting and fondling is a normal way of showing deep affection and that such preliminary activities are a necessary prelude to good marital adjustment and every teenager has read at least one book by a psychiatrist, psychologist or possibly a minister who sagely pontificates that while caution is advisable and love is important, no activity involving two consenting adults is necessarily harmful or really sinful. Any reader who has reached the age of 16 is certain that he is an adult . . ."

Walters, McKenry, and Walters (1979) indicate that the knowledge that adolescents have regarding sexuality and nature of conception is limited. These youths definately know that pregnancy results from intercourse, but have no idea at all when the egg is most likely to be fertilized. Many believed that conception occurs near menses, and that mid-cycle is the safest time for intercourse.

Hornick, Doran and Crawford (1979) studied contraceptive use among

adolescent females who were sexually active. They found that a general acceptance of oneself as a sexual person (i.e. having sexual relations) seemed to be the key to contraceptive usage. They found further that the level of commitment of the relationship, and whether there was a condition of love was an important factor in contraceptive use.

McKenry, Walters and Johnson (1979) reviewed the literature on adolescent pregnancy. They found that adolescent premarital intercourse is beginning at younger ages and that overall, the incidence of intercourse is increasing for adolescence. They found further, that contraceptive use is higher by girls who have sexual relations frequently, and by non-promiscuous girls who are in fairly stable relationships. Contraceptive use is lowest in those girls who have occasional sexual relationships that are generally unplanned, or with a casual acquaintance.

Smart and Smart (1973) deal with how each sex develops their perspective sexual identity. Masculine identity is closely linked to activities and achievements, therefore boys are encouraged to become assertive and independent. A boy has to deal with authority - without fighting it, yet maintaining his sense of self.

> "But before he can identify a sexual identity in relation to the opposite sex he needs a foundation in the identity which requires achievement and assertiveness. Some sort of vocational success perhaps a plan or commitment will serve". (p. 145)

Smart and Smart believe that boys clearly see their future roles as breadwinners, and that in order fulfill this role - they must achieve. Societal changes in some of the role expectations for men make it difficult for some boys to know where they are heading. Some youths are developing life styles based on the flexibility that is becoming apparents in role changes.

Smart and Smart state the development of feminine identity is very

different from that of boys. Being skilled at interpersonal relationships seems to be what is perceived as important for girls. Girls are encouraged to be sensitive, warm and sympathetic. Some girls see their future roles mainly as wife and mother.

Societal and value changes are affecting the way girls develop their sexual identities as well. It appears to be a growing trend that girls now want careers outside of the home, and don't necessarily see their self worth as dependent upon a husband's career. The women's liberation movement has given girls much more flexibility and freedom than was perceived in the past.

Jessie Bernard (1975) states:

> "Young women rarely ask the old marriage vs career question any longer. More and more they ask instead: What else am I going to do besides being a mother?" (p. 247)

The socio-economic background of the adolescent determines greatly the development of the sexual identity. Children from families living in poverty don't often think of careers for future. There is no little attention to the "marriage vs career" decision. These adolescents are struggling to meet basic physiological needs. They most often grow up with rigid stereotype roles of men and women, and see no opportunity to break out of their socio-economic condition. Men are often seen as brutal and women as ineffectual. Wife-beating is frequent and incest is often present. (Konopka 1966).

The adolescent growing up in this environment certainly develops a sexual identity that is different than the adolescent from more middle class families as described by Smart and Smart. Regardless however of socio-economic background, all adolescents do have relationships that are sexual in some way, and all develop belief systems about the roles of males and females.

Kovar (1967) describes the development of sexual identity in the following way:

> "The girl focuses attention on her body as a consequence of these crucial body changes (maturing of primary and secondary sex characteristics) and also of her desire for acceptance by her contemporaries and her anticipation of utilizing her body in relations with boys. The perception and the evaluation of her body ever changing are basic experiences in her life". (p. 24)

e) DEVELOPMENT OF LIFE GOALS "WHAT AM I GOING TO DO TO BE SUCESSFUL"

The task of developing life goals is closely linked with role experimentation and the development of a sexual identity. Through peer group experimentation, and through the process of learning the roles of man and woman, the adolescent is faced with thinking about what will be done during the rest of one's life in order to be sucessful.

Reference can again be made to Konopka and her study of girls from lower socio-economic backgrounds. These adolescents have never experienced success, in the usual sense. Often the only success experienced in their lives is in being a successful delinquent who doesn't get caught or prostitute who is "popular". These are hardly socially acceptable life goals, yet these are the only future goals seen as attainable by a portion of adolescent girls, as this is all they feel capable of becoming.

Conger (1977) suggests that if an adolescent is to have a meaningful purpose in the world then he needs to be exposed to and participate in vocational activities in order to test his skills against the real world. This often isn't done because it is seen as impractical. In our culture, however, vocational identity has a major role in the overall sense of identity of many persons. Most adolescents, unfortunately, only have a vague idea of the nature of the many different kinds of jobs that are available, or in which they would be successful. Thus they have a difficult time deciding upon an occupation. The closer that adolescents get to needing to support themselves, the more they think about life and vocational goals.

Conger points out (as did Konopka) that social class influences the choice of life and vocational goals. Upper middle class children are discouraged from taking up lower-status occupations. (Most young people however, aspire to jobs with a somewhat higher socio-economic status than those of

their parents). Working class youth don't feel that they have the opportunities to achieve higher status jobs. When parents have no expectations that a child will finish grade 9, it is unlikely he will think about becoming a doctor. Conger believes that family influence has a significant role in vocational choice. Parental support and motivation is a critical factor in career choice. Supportive parents increase ambition and thus allow a child to choose a high status occupation.

As society becomes more complex, Conger states it is more difficult for adolescents to choose their life goals. There are many options, but not many opportunities to try out the options.

Thornburg (1975) cites research that suggests that the following factors influence adolescent aspirations -

> "Social class of parents, aspirational urges of parents, socio-emotional adjustment of the adolescent, social status of peers, school performance and need for achievement." (p. 410)

Thornburg also suggests that needs affect aspirations. He identifies a range of goals including occupation, residence, and income. These needs may be perceived consciously or appear as a vague interest that draws a person to a certain area. Occupational shifts accompany changes in needs. Economic facts influence occupational choice of adolescents as most prefer a modest but secure income. Education influences career choice as it provides an awareness of opportunities.

Thus the literature seems to state that the development of life goals is contingent upon many factors - parental values, social class, peer relationships and personal values.

B) FEMALE ADOLESCENTS

The literature on female adolescents is not as plentiful as the literature on male adolescents. There are, however, three writers who have worked extensively with females. The first of these is Gisela Konopka who worked with delinquent girls while they were living within a treatment institution. The second is Lillian Cohen-Kovar who developed a theory on the faces or roles of the adolescent girl. The third writer is Alfred Friedman who worked with sexually "acting out" females.

In her book The Adolescent Girl in Conflict, (1966) Konopka attempted to explain the causation of delinquency in girls. Konopka lived with the girls she was studying in order to develop a level of trust that would allow the girls to share personal information and perceptions with her.

One of Konopka's first comments in her book was how deeply personalized all of the problems of the deliquent adolescent girl are. Regardless of her offence, it was most often accompanied by some sexual acting out behavior which thus involved the girl's total being, self-concept and relationships with others. This delinquency and sexual acting out often have people shy away from the girl. The girls in Konopka's study felt extreme loneliness which was accompanied by being unprotected by parents, incapability of forming meaningful relationships and being surrounded by anonymous all powerful world. These girls feel that there is no way out of their loneliness, and that there is no opportunity to succeed. The adolescent girl in conflict sees the adult world as brutal (men), ineffectual (women), phony, hypocritical and an anonymous authority. Because of this, there is much resistance to trust, and behavior is geared to fighting the mores and values of the society at large.

The rebellion and anger against adults is often fed by relationships with social workers and other staff in the justice system. These staff

often have high and somewhat unrealistic expectations of the girls in their care. The staff have demands and restrictions, but seldom are they warm and caring. The staff often present themselves as perfect - that they have never made mistakes. When the girls finally see that the staff have "feet of clay" then the girls feel more contempt for the adult world, and feel more justified in discounting adults. Behind these feelings, of course, are the girls' incapacity to understand themselves and their feeling of hopelessness. This concept of the faceless adult authority and the resulting loneliness is one of Konopka's key concepts. One of the major ways to understand the girl in conflict is to understand this feeling of loneliness.

Often the label of delinquent and the removal of the girl from her home environment leads the girl to feel even more discouraged. She feels isolated and in-between the values and cultures of her home and the institution or society at large.

The need to belong is very strong for the girl in conflict. Often there are very romanticized views of marriage, as marriage is seen as a way out of the loneliness and the poor home environment, and a way to belong to someone. The only people who are prepared to become friends with the girl in conflict are others who feel the same and behave in similarly destructive ways. Joining a crowd of other delinquent girls fills some needs but not the ones for a deep personal relationship. Thus the loneliness continues.

In their boy-girl relationship, the delinquent girls often take much abuse. They may get talked into an "emotional" rape, and they are often beaten. Regardless of the quality of the relationship, it provides a sense of self worth never felt before because they are needed and wanted. Some girls, however, because of their low self esteem, become involved

sexually with other girls. This may be due to feeling unattractive to boys rather than to homosexual drives.

Konopka believes three other key concepts affect how the girls see themselves and thus how they behave. The first of these is the dramatic biological onset of puberty. Because girls can become pregnant (unlike boys), then sexual relationships can often promote poor self esteem, especially if pregnancy results, or the fear of pregnancy is present.

The second concept is the complex adolescent identification process, proper identification has been difficult when parents have been absent or if they were inadequate role models. There is no one to help form a positive identification.

The third concept is the changing cultural position of women. The girls see that there is little legitimate outlet for anger and aggressive drives. They have become aware of and resent the double standard. They feel that their ambition is thwarted by being female and that there is no way out of this dilemma.

As mentioned earlier, Konopka's fourth concept deals with the faceless adult authority.

Although this work was published in 1966, and the field of adolescence has developed since then, Konopka's work is still an accurate and sensitive reflection of the adolescent girl in conflict.

Lillian Kovar-Cohen wrote Faces of the Adolescent Girl, (1968). It is Kovar's beliefs that a girl is perceived in a certain fashion by her family and then receives reinforcement from them for acting this "role". The girl then continues to affirm herself in the role and for the behavior in which she was confirmed.

Kovar sees most girls as having been confirmed in one of the following five roles:

Autonomous girl
Adult oriented girl
Peer oriented girl
Delinquent girl
Anarchic bohemian girl.

THE AUTONOMOUS GIRL

This girl, Kovar sees as the ideal. Her autonomy has been developed by parents and other significant adults for many years. She tends to be spontaneous and genuine. She is able to develop her individuality and achieve competence in some area of her choice. She is able to think and feel for herself. This autonomous ideal is able to be actualized when the family relationships promote being autonomous as the ideal, when social and societal barriers do not preclude confirmation as genuine by people other than the family, and when the girl's peer group is also autonomous.

PEER ORIENTED GIRL

The peer oriented girl has not had a meaningful relationship with her parents. She has been confirmed and reinforced by her parents for external or superficial aspects of her personality, such as being pretty, fun-loving or popular and not for any meaningful behavior or values. These external characterizations become the reason for living, and all else is seen as achieving these goals. The girl thus gets lost in relationships with peers because they can provide the most meaningful reinforcement of these characteristics for an adolescent.

This girl is basically convinced that she is not worth loving unconditionally or in her own right, but only for what she looks like or gives out. She cannot set her own limits in relationships, but goes along with whatever the peer group, or boy she's with wishes. The peer relation-

ships dominate most of what she'll do (e.g. drinking or experimention with drugs).

This girl is not concerned with her future, she doesn't have long range goals, but sees most things in terms of what can be done for fun.

ADULT ORIENTED GIRL

The adult oriented girl is the mirror image of what her mother would like her to be. She has been confirmed as the good one; that is, if she behaves. This girl carries completely her parents' values.

The adult oriented girl is concerned more with the need for controls than with the desire for any freedom. This adherence to the need for controls and to her parent's values often mean alienation from peers. This alienation encourages her to develop even stronger ties with her mother, as mother is the only one that she can talk to. Relationships with boys are too threatening. She is afraid of becoming involved sexually (which her parents have told her is wrong). She does, however, see finding a husband and getting married as more important than a career.

DELINQUENT GIRL

Kovar has categorized the delinquent girls based on the legal label that was received as a result of having become involved with the court system.

Kovar's description of the delinquent girl is quite similar to Konopka's description of the adolescent girl in conflict. These girls have often been labelled as bad, and much of their deviance is "secondary" in reaction to the label. These girls have had no warm personal relationships. Most likely they were neglected and/or rejected, which reinforces the feeling of being bad and the low self-esteem. Relationships with boys are frantic.

The girls don't feel that the relationship will last long and are therefore, always searching for a new boyfriend, ensuring a short term relationship. Sex isn't seen as pleasurable, but more a way to keep the boy. Much of her association with sex is of rape and violence.

The delinquent girl often views life as a power struggle where the strong are attempting to impose their will on the weak. The delinquent girl is bored and frustrated and tends to join groups that offer immediate excitement. This is where conflict with the law often takes place. The girl is concerned more with immediate gratification than with the consequences of her behavior, and sees the police/legal interventions as another power struggle, where she is now the weak.

THE ANARCHIC BOHEMIAN GIRL

This girl is not motivated to look for relationships with others, but rather is looking for the freedom to be herself. She sees herself as an integral part of the "natural" world.

> "She wants to absorb this world in its richness and immediacy, undiluted by societal proscriptions. She wants to express her primitive vitality and thereby experience her own unique sensuous self". (p. 97)

The anarchic bohemian is looking for a heightened perception and greater awareness of life, beyond what she can normally see. She tends however, to lack the security of relationships with others, and searches for awareness on her own. This girl continually attacks her parents' and society's values. She claims all are hypocrites and too materialistic. This is a very intelligent, intellectual girl who perceives injustice in her life and the lives of others. The anarchic bohemian usually is a social isolate. She is unable to keep friends as she lacks trust. She oftens satisfies her own whims not caring whether she is inconveniencing others. Sexually she is a free thinker, out looking for sensuous moments with a

variety of men. The anarchic bohemian is clearly a rebel. She rebels against family, peers, school, sexual values and society in general.

Kovar concludes her study by saying that the confirmation - affirmation process that began early in childhood is very powerful. She believes that this cycle can be broken by establishing radically different relationships away from the home or by involving the girls who are having serious difficulty in psychotherapy.

Alfred Friedman edited Therapy With Families of Sexually Acting Out Girls, 1971. The first part of this book provides an overview of Friedman's theory of the sexually acting out adolescent female.

One of Friedman's first points is that the sexual acting out may be a sign of family problems. For many adolescent girls, sexual acting out may be an expression of rebellion against their parents. The parents are very concerned with how their daughter uses her body. The young girl may not derive much pleasure from sex, but has learned that in some obscure way she can get back at her parents through the use of her body.

Friedman believes that for girls being sexually delinquent is worse than any kind of acting out than a boy may do. He states that the sex is without meaning or pleasure. The sexually acting out girls often confuse sexual popularity with genuine care and concern. They receive little affection from parents and thus look for it in other ways.

Friedman's comments:

> "Sexual delinquency among girls often reflects the breakdown of parental control, a generation gap and rebellion against authority and an acute disturbance in the parent-adolescent relationship just as do many other forms of juvenile delinquency." (p. 7)

Friedman's review of the literature on the causes of female sexual acting out states that there are many. The range is from primary emotional deprivation, to rejection by fathers, to inappropriate role

models in the parental marriage, to a defense against a homosexual threat. Regardless of the cause of the acting out, it can in most cases be seen as a genuine cry for attention and help, affection and understanding by the girl and her family.

These thr writers, Konopka, Kovar and Friedman, provide a good understanding of the adolescent female, particularly the girl who is having some difficulty in managing her life in a constructive way. Konopka and Friedman dealth mainly with the delinquent girl, whereas Kovar looked at female adolescents in totality. All three perspectives add to the knowledge of one interested in female adolescent development.

C) THE FAMILY ADJUSTMENT TO THE CRISIS OF ADOLESCENCE

Parents are often ill prepared for and feel inadequate in coping with the sudden changes in family life when their children reach adolescence. Children who were previously quiet, well-behaved and who listened to their parents, may become (in what seems to be overnight) loud, destructive and ill mannered. They are no longer prepared to listen to their parents, as they no longer see the parents as having a more valid perception of the world.

Minuchin (1974) suggests:

> "As the child matures, especially during adolescence, the demands made by the parents begin to conflict with the children's demands for age-appropriate autonomy. Parenting becomes a difficult process of mutual accommodation. Parents impose rules that they cannot explain at that time, or that they explain inadequately, or they regard the reasons for the rules as self-evident when they are not self-evident to the children. As children grow older they may not accept the rules." (p. 58)

Although the members of the family system remain the same, the roles and relationships between these members change greatly. As the adolescent expresses his individuality, he is telling his parents that their previous way of raising him is no longer valid and the adolescent insists that his parents adapt and change with him. This demand for change comes both verbally and non-verbally. Verbally, the adolescent challenges his parents' authority in a way that he never has before. Non-verbally, he no longer responds in the same fashion to his parents' attempts at correction. In order for the family to maintain some sense of normalcy, the entire family has to adjust with the adolescent to the developmental crisis.

Fisch, Watzlawick, Weakland and Bodin, (1973) comment on these family changes:

> "'Everyday difficulties' are considered those arising most commonly during normal transitional stages in the careers of

> individuals and families, when shifts in family functioning and redefinitions of relationships become necessary. These transitions occur most often at certain specific points in time, eg. from courtship to marriage ... and even more so as the child becomes involved with peers in the adolescent period ..." (p. 609)

Golombek, Wilkes and Froese (1977) discuss how an adolescent child often stirs up unresolved feelings and conflicts in the parents, who may thus react to their child with extreme inconsistent or unusual behavior. This parental stress is likely to occur in three areas - sexuality, authority and values. These are areas where children traditionally challenge their parents. This is even more difficult in families where the parents are unsure of themselves, of their values, authority and sexuality.

A family ill-equipped for the developmental crisis of adolescence, may respond to the problem as if it were a situational crisis. Often the nature of the adolescent acting-out may precipitate a situational crisis. Steinhauer and Dickman (1977) state that when a situational crisis occurs simultaneously with a normal developmental crisis, then the combined impact on the family has a long-lasting effect. This would certainly be an indication of the need for family therapy.

Ackerman (1975), believes that the misbehavior of the adolescent is a symptom of the family pathology. The adolescent acts out in public, the private anxieties of his family. This often creates a situational crisis for the family. This is more typical of disturbed or problem adolescents than a "normal" adolescent.

Schiamberg (1975) studied the adolescent-parent struggle, and the family's adaptation from a cross-cultural perspective. He believes that the conflict between the generations is directly related to the socio-cultural background in which the conflict occurs.

> "The conflict of generations would seem to be best explained from a cultural anthropological view which recognizes that the parent-adolescent relationship is related not only to particular personalities and temperaments, and particular circumstances, but is also related to cultural and societal values and norms which influence the parent-adolescent through the medium of the family". (p. 292)

The parents may react strongly to some of their adolescent's behavior because the norms of society dictate that they should be upset and should react.

Schiamberg (1975) says that in India there is very little conflict between adolescents and their parents, and that there is no need for the family to adjust to the crisis of adolescence. The reason for this is the societal emphasis on the quality of interpersonal relationships, and the little value placed on material existence. The typical household in India is an extended family rather than a nuclear family. The extended family allows for more relationships and more distribution to feelings over more people than does the nuclear family.

Indian life is structured with an emphasis on worship and meditation, and on Asraimas, or age grades which clearly dictate roles and behaviors at different stages in life. A man, according to the Hindu religion, is born with three debts (to the Gods, to the sages, and to his ancestors), and his life is carefully organized so that he is continually paying off one of these debts. Respect for elders is a strong requirement for the behavior of all adolescents in India. These structures and rituals are powerful, and thus do not allow for an adolescent crisis. Every Indian adolescent knows where he is headed and has no need to search for his identity.

The traditional Chinese (prior to the communist takeover) had strong factors that determined the locus of family power. Males were always dominant over females. Older generations were more respected than younger,

and had more knowledge. Oldest siblings always had preference over younger. Adolescents were immersed in a culture which stressed filial piety. The most respected traditional relationship of the Chinese was that between father and son - this was dominated by the respect that the son showed his father. This relationship structure left no room for adolescent rebellion.

Because there were no choices in traditional Indian and Chinese culture, - that is, the adolescent was trained all his life for the tasks in which he was to be successful as an adult, Schiamburg states there was no need for rebellion. Where there are no choices and everyone accepts the life style and values, there are few frustrations in interpersonal relationships or role expectations. The adolescent in Western Society, however, is faced with many choices and thus has a greater source of supply of frustration.

Offer and Vanderstoep (1975) looked at families containing adolescents and identified when family therapy should and should not take place. They identified certain adolescents who refused to be seen with their parents as inappropriate for family therapy. Their belief is that the wish of the client has to be taken into account. They also believe that the therapist needs to be flexible and work with an entire family where feasible and appropriate, and not to withdraw services if one part of the family system refuses to go on with therapy. Offer and Vanderstoep point out that family therapy with a family containing an acute schizophrenic is not appropriate until the schizophrenic has established a relationship with the therapist.

Offer and Vanderstoep also point out that it is helpful to have the entire family in therapy during the adolescent crisis when there is much acting out (e.g. drug abuse, promiscuity, violence, etc.). The family

can learn through therapy that the adolescent acting out is not without meaning. The acting out is, in fact, a response to the verbal and non-verbal cries given out by other members in the family. In therapy it is clearly demonstrated that the behavioral response of one part of the system reflects tension in the whole family system.

Parenting style has been shown to have an effect on how both the adolescent and the parent cope with the adolescent crisis. Baumrind (1975) studied parenting styles and on the basis of her study constructed eight adolescent prototypes. They are as follows:

Social Agent vs Social Victim

Traditionalist vs Alienated

Socialized vs Delinquent

Humanist vs Anti-humanist.

She proposes that parental style (whether authoritative, or overly protective, the amount of family communication, type of discipline provided, whether there are strong family ties, and high demands on children, etc.) determine where the adolescent will be in the eight prototypes. She also proposes that harsh, exploitative and arbritrary treatment by parents is strongly connected with anti-social aggression in adolescents. Clearly how the parents view the world (whether they feel like victims, perceive themselves as alienated, etc.) has a large impact on how they raise their children. The parent who is harsh and arbitrary will tend to utilize that style more as the adolescent acts out, whereas the parent who is humanistic will continue to ustilize reason and love rather than strict control when there is difficulty with their child.

It is important not to blame the parents as the sole cause of some adolescent difficulty or acting out. To blame the parents is not looking at the interaction in the family system that is currently maintaining

the dysfunction. All family members need to adapt and change in order to sort through family difficulties that may be highlighted by an adolescent crisis.

This section dealt with several aspects of the parent-adolescent relationship and the changes that it must undergo as the adolescent develops. Adolescence in Western society can renew unresolved conflicts in some parents and can cause situational crisis. In some Eastern societies, however, adolescence renews and re-establishes cultural values emphasizing respect for elders and family ties. Some indications for family therapy were addressed as well as effect of parenting style on the adolescent.

D) THEORY ON FAMILY INTERVENTION IN THE INTERACTIONALIST OR SYSTEMS PERSPECTIVE

The family therapy literature written on the interactionalist/systems approach has many themes or ideas that appear in the works of various authors (Minuchin 1974, Haley 1976, Walrond-Skinner 1976, Watzlawick et al 1974, Golan 1978). Several of these common themes will be discussed in this section.

A definition of the interactionalist or systems approach needs to be offered prior to the discussion of themes. The systems approach focuses on analyzing the transactions that take place between the members of a family, group or social system. The entire system (family or group) is seen conjointly for therapy where the focus is shifted from the behavior of the "identified patient" to the family transactions as they unfold during the course of therapy. The systems approach believes that when one family member is in distress, all of the other family members are feeling this pain as a result of their continual interaction with the person in distress. One family member often "acts out" or expresses the non-productive interaction patterns that the family is utilizing and thus the entire system needs to be treated in therapy and not just the identified patient.

Offer and Vanderstoep (1975) defined Haley and Minuchin as systems analysts. Systems analysts are practitioners in the field of family therapy who do not utilize the "medically oriented disease-treatment scheme" (p. 152). Instead, they argue that the only way to provide meaningful therapy is to work with the entire family which is the primary unit of analysis for assessment and intervention. Second, the analysis of the unit is focused on the family as it is seen as a living system. Systems analysts believe that the only possible approach to distress is attending to the system.

Walrond-Skinner (1976) furthers the theme of one person's problems being reflective of a family problem. She tied general systems theory to family therapy theory. She deals with the idea of causality. Her view is that the concept of causality within systems theory requires one to look at the total view of the family process. The family problem cannot be blamed on any one member of the family but is seen as the responsibility of the entire family system. Change will only occur through changing the transactional patters, either through conscious understanding (insight) of how the system functions, or through unconscious communication changes developed through the intervention of the therapist. (Haley clearly favors the latter method of change, believing that insight often gives a system an excuse to remain the same, or can offer opportunity for resistance).

Minuchin (1974) also discusses how an individual in the system adapts to and is reflective of his system.

> "The individual can be approached as a sub-system or part of the system but the whole must be taken into account." (p. 9)

Minuchin furthers this discussion by proposing that changes in the family structure contribute to changes in both behavior and inner psychic processes of the system members.

One of the first points that Haley (1976) makes is:

> "A problem is defined as a type of behavior that is part of a sequence of acts between several people". (p. 2)

This statement demonstrates Haley's view of family systems theory and his belief that an individual's problem(s) has its roots in a family or systems problem. Thus the individual needs to be treated within the entire system. He furthers this theme:

> "Usually family members say that one person is the problem. The therapist's job is to think of the problem in terms of more than one person. By thinking that way, he is most able to bring about change." (p. 33)

As mentioned earlier, Walrond-Skinner linked general systems theory to family therapy theory. One of her major premises deals with the composition of the system. She perceives the system as a whole that has component parts (family members) and attributes (roles and rules). These can only be understood as functions of the total system. Therefore, the systems analyst whose focus is the whole family looks carefully at the quality and quantity of the transactional patterns and sequences that are present between the family members. These sequences are visible in all of the activities of all of the family members.

Satir (1975, 1972, 1967) discusses extensively the transactional patterns that occur in families. She has outline five types of communication patterns that an individual uses, and her interventions are directed at changing the communication/transactional patterns that appear.

Minuchin (1974) posits that each family's structure develops an invisible set of functional demands that organize the ways in which the family members can interact. These develop into transactional patterns. The transactional patterns regulate the family behavior in two ways:

1) Generic - this involves roles such as husband-wife, parent-child, and their complimentary functions;

2) Idiosyncratic - this involves mutual expectations of family members developed over time through years of explicit and implicit negotiations around daily event.

Walrond-Skinner (1976) views the system as having a distinct boundary which interfaces with the outer environment. The system also has (dyads and triads) subsystems within itself. The external boundary of the system is clearly definable, and thus makes the focus of intervention clear. Minuchin (1974) describes two types of family boundaries - enmeshed and disengaged. Enmeshed boundaries are diffuse and blurred. Disengaged boundaries are inappropriately rigid. All families fall somewhere in between the two, often having some subsystems with diffuse

boundaries and others with enmeshed. However, the family with enmeshed boundaries can respond to any variation from the accustomed ways of relating with excessive speed and intensity. The family with disengaged boundaries tends not to respond at all when a response is necessary.

One theme that is found throughout the literature deals with analysis and assessment of the family unit. Minuchin (1974) provides a structure for viewing families. This structure is a method of critically studying a family and its process. He suggests that absence of problems is not enough of a criterion to distinguish a normal family from an abnormal one. He further suggests that a conceptual schema is necessary to analyze a family. This schema, which is based upon viewing the family as a system operating within a specific social content, has three components. Minuchin discusses the components:

> "First the structure of the family is that of an open socio-cultural system in transformation. Second, the family undergoes development, moving through a number of stages that require restructuring. Third, the family adapts to changed circumstances so as to maintain continuity and enhance the psychosocial growth of each member". (p. 51)

Minuchin further suggests that viewing the family as a social system in transformation, highlights the fact that certain family processes are transitional and are present as a result of the changing situation of the family. Therefore, in this orientation, families that seek help are viewed as families undergoing developmental changes, rather than families with pathological problems.

Golan (1978) suggests the terms "critical condition" or "crucial situation" to describe the characteristics of specific stages in normal life development which tend to make the individual more vulneralbe to periodic stress and less adequate to cope with it as it arises. She points out that when the family's children reach adolescence, parents often

feel that their integrity and self-esteem are threatened because the adolescent continually attacks them. She states that these conflicts are a part of normal transitional or developmental crisis. Golan also points out that treatment in situations involving developmental difficulties often starts with a problem that is situational in nature (e.g. a teenager is arrested for car theft). Underneath the anger and the situational crisis is the client system's feeling that things are different than they used to be, and there is a feeling of loss of control as they move into a new stage of development.

Continuing on the theme of assessment, Minuchin stresses the importance of assessment of the family structure prior to the setting of therapeutic goals. The therapist's intervention must facilitate the transformation of the family system in the direction of those goals. The content of the therapy must relate to the current life experiences of the family, as the content of the family's communication is transcended by the structure of the family. The approach of the therapist must be one that the family can accept, the therapist must accommodate himself to the style of the family, if he is to be successful.

Minuchin identifies six areas that the therapist concentrates on when conducting an assessment of the family (p. 130):

1) The family structure - its typical transactional patterns and the alternatives available;

2) The system's flexibility - its capacity for restructuring and elaborating as demonstrated by shuffling subsystems;

3) The family system's resonance - its sensitivity to the individual member's actions (enmeshed or disengaged responses);

4) The family life context - analyzing the support sources and points of stress in the family's relationship with the outside world;

5) The family's developmental stage - the performance of tasks appropriate to that stage;

6) The identified patient's symptoms - the way the family uses these to maintain their preferred transactional patterns.

Haly (1976) doesn't deal specifically with an assessment process. He does, however, describe a format for gathering information, problem inquiry and observation of the family interaction in his discussion of the first session. One point that Haley makes deals with a way for the therapist to determine how well motivated and likely to work the family will be. If in the initial interview the family members emote strongly and are obviously involved in what is being discussed, in all likelihood they are in a crisis state and are therefore unstable. If the family is calm and detached, it is likely that their situation is reasonably stable. Haley further points out (in clear agreement with the major crisis theorists) that the family in crisis will be more motivated to work and change its interactive patterns and therefore is easier to work with and affect change within than the family that is relatively stable in its situation.

Watzlawick et al (1974) have designed a four step procedure that is used at the Brief Therapy Institute to assess a family (or individual) problem and then to design the therapeutic plan:

1) The therapist and client reach a clear definition of the problem. This is stated in concrete terms;

2) The therapist investigates all of the solutions that the family has attempted prior to this therapy;

3) The therapist and client reach a clear definition of the concrete change to be achieved;

4) The therapist formulates and implements a plan to produce this change.

Walrond-Skinner does not separate assessment from the work that begins at the first contact with the family. The therapist reflects on each piece of the family picture as it appears before him. She suggests that the therapist needs to evaluate with the family its communication patterns, internal alliances, family roles and the way in which the family system

affects the therapist. The therapist needs to consider the role the family wishes of him, the enmeshed or disorganized properties of the family, and the degree to which the homeostasis is operating within the family. She believes the therapist also has to consider the role the identified patient has in the family system, and the verbal and non-verbal content that emerges.

> "The therapist's diagnostic task is to try to translate the seemingly random non-verbal activities of individuals into a pattern which is meaningful in terms of the whole system." (p. 40)

Another theme that occurs in the literature is that of the therapist "joining the family". Walrond-Skinner (1976) writes that at the point that the therapist becomes involved with the family, he becomes part of the system (has joined the system). This is because the therapist is affecting the transactional sequences of the family and thus affects how subsystems are related to and how the family perceives itself. Minuchin states that when a therapist works with the family, his behavior becomes part of the context. The therapist and family system join together to form a new therapeutic system which then governs the behavior of its members. Minuchin suggests that the therapist joins the family with the goal of changing the family structure in a way that the family experiences a degree of change. The therapist speaks in patterns and expressions that the family uses so that they can easily understand him. The therapist has joined the family to change its relationships, patterns, sequences and responses.

A final theme which may be considered is that of giving directives or tasks to the family members. Haley cites three purposes for giving directives:

1) Directives provide a way of giving the family an opportunity to behave differently, and thus have a new and different experience. This meets one of the goals of therapy which is to have clients behave differently;

2) Directives provide a way of intensifying the relationship with the therapist. The therapist has given the family a task that it must perform. The family members have then to decide whether or not they are going to perform the task. After having made their decision, they then wonder about the response they will receive from the therapist upon hearing the successful completion or failure to perform the task. Thus the directive serves to keep the therapist, the past session and the next session, foremost in the mind of clients;

3) Directives also provide a way for the therapist to gather information. The way that the family responds to what is asked of them is indicative of how they will respond to the changes wanted of them over the course of the therapy.

Haley utilizes paradoxical tasks when the family has stabilized around one person as being the problem. A paradoxical tasks asks the family to change, but at the same time tell them not to change and thus attacks the problem in one or two ways, they either change or don't change which gives the therapist more process information with which he can work. These tasks seem paradoxical because the family feels that the therapist says that he wants to help them change, yet at the same time he is asking them not to change. Haley (p. 68) cites an example of a paradoxical task by discussing a family who enters therapy because their child will not go to school. The paradoxical task deals with discussions surrounding why it is better for the child and the family. if the child does not go to school.

Watzlawick (1974) also discusses the utilization of tasks or directives to help the client to behave differently. Watzlawick uses tasks to have clients move from first order change to second order change. In first order change the client utilizes "more of the same" behaviors to solve problems and becomes unable to move - all his solutions end in failure. Second order change is a change to an entirely different way of perceiving the problem and thus an entirely different way of behaving. This is accomplished together with reframing the problem so that it is redefined

as being something different (and more soluable) than what the client initially believed. Watzlawick reframes the problem, gives the client a directive to follow (based on the reframing) and the client moves to second order change. In his 1980 workshop in Winnipeg, Watzlawick gave the following example of reframing a problem. He cited the case of a family with an anorexic teenage daughter. The therapist told the anorexic not to eat for the sake of her family. The family had been responding to the not-eating as a crisis but when the not eating was reframed as a therapeutic directive, the problem was not seen by the family as being critical.

Minuchin (1974) discusses the use of therapeutic tasks to change boundaries of subsystems in order to have family members experience each other and their problems in a new light. The family members are re-positioned by the therapist's interventions. Tasks are a part of the restructuring process and are designed to be carried out at home away from the therapist. Minuchin states the following:

> "The use of tasks has many advantages. A focus on tasks forces the therapist to deal with the family structure and transactional patterns, rather than with the individual members' particular characteristics. Tasks draw attention to new possibilities for restructuring the family. In formulating tasks the therapist must clarify his map of the family and establish specific goals as well as specific steps toward these goals. Tasks are also a valuable means of testing family flexibility." (p. 151)

The way that the family respond to the task gives the therapist a better understanding of where the family is and where they need to move.

Walrond-Skinner discusses task-focused therapy and states that it is an opportunity for the family to experiment with new adaptive patterns of responding to each other. She further states that this is an experiential approach to change, and that it helps the family to engage on problem solving. Walrond-Skinner's definition of a therapeutic task is as follows:

> "The physical enactment of an emotional reality - either as a means of heightening the family's awareness of its existing dysfunctional relationships or as a means of restructuring those relationships to achieve the established treatment goals." (p. 70)

Walrond-Skinner suggests that a task have a clear purpose within the on-going therapy, that it has to be somehow practiced within the session, and that the family is capable of performing the task in their life outside of therapy. The task is only meaningful as it restructures relationships upon its performance.

Thus the utilization of tasks are viewed similarly by Haley, Minuchin and Walrond-Skinner. Watzlawick defines when the task is to be assigned in a slightly different manner (first and second order change).

In summary, the above discussion addressed several themes that are present in the literature on family therapy from an interactionalist perspective. The interactionalist or systems approach focuses on the entire family rather than on an identified patient. This allows for problem resolution to take place in the natural environment, rather than dealing with and treating one family member in isolation from the others.

CHAPTER II. THE PRACTICUM EXPERIENCE

A. THE SETTING

The practicum was conducted at the Youth Psychiatric Services Department of the Health Sciences Centre. Supervision was provided by the Director of Youth Service, and two professors from the School of Social Work. The former supervised one case where the client was a 16 year old female in intensive psychotherapy. The School of Social Work supervisors provided clinical supervision for the family therapy cases. The practicum was conducted three days a week from September, 1976 until June, 1977.

Youth Service is the adolescent psychiatric department at Health Sciences. At the time the practicum was conducted, Youth Service provided an intensive day treatment program (plus two evenings a week) to approximately twenty adolescents. In addition, the service also completed assessments on adolescents that were referred from various outside agencies (Children's Aid, Society for Crippled Children, etc.), as well as for other wards in the hospital. Each adolescent on the service had a prime therapist who was responsible for providing the psychotherapy and a secondary therapist whose role was as back-up to the prime therapist. This person did not have formal sessions with the clients.

Each adolescent on the service was also expected to attend the school program offered. Group therapy was provided three days a week with attendance optional. Recreation and occupational therapy were also provided to those on the service.

Family therapy was not provided as a matter of course, but only in rare circumstances.

The student worked as a social worker on staff at Youth Services. She was a prime therapist offering psychotherapy to one of the patients on the service, and worked with the family of one current Youth Service patient, and one former patient. As well, the student assessed cases that were referred from outside agencies and provided therapy to two of these referrals. This was done as a staff of Youth Service. Supervision was received from the School of Social Work, and not from the Youth Service Director. Four out of the five cases worked with during the practicum involved adolescent females and the fifth case involved an adolescent male.

B) THE CASES

1. Individual Therapy

Individual therapy was provided for two adolescent girls at Youth Service. One of these girls was a full-time patient of the service, and the other had been referred for assessment and treatment by The Society for Crippled Children and Adults in conjuction with her high school teacher. A report of the latter case will be provided here.

Donna

Donna was a 14 year old girl who was confined to a wheel chair due to having Cerebral Palsy as a result of her premature birth (which took place at 30 weeks gestation). She was reffered to Youth Services dually by her high school teacher and her social worker from the Society for Crippled Children and Adults. There was a concern over Donna's increasing avoidance of reality. Examples of this avoidance were:

1) Donna had continual asthma attacks, severe enough to require hospitalization. These were to avoid problems at home, and were seen as self-induced through hyperventilation;
2) Donna insisted she was pregnant, she pretended to have morning sickness and stuck her stomack out in an attempt to look pregnant. She became hysterical when the results of her pregnancy test were negative. (Sexual relations for Donna would be almost impossible.)
3) Donna developed what her teacher coined "Sybilitis". Donna had watched the T.V. series "Sybil" and been highly influenced by it. Donna "developed" every problem that Sybil had.
4) In addition, Donna attended school only two times a week. There was also concern that Donna was not able to cope

with the home situation which was highly unstable and quite destructive for Donna due to numerous family problems.

Donna's behavior had deteriorated greatly from September, 1976 until January, 1977 when the referral was made. Both her teacher and social worker believed that Donna would regress further unless she received some intensive help immediately.

Family Situation

At the time of the referral Donna was living with her father, maternal grandmother and older brother and sister. Donna's natural mother had left her husband when Donna was two. Donna's mother asked her own mother to care for her children. Mr. B and Donna's grandmother were living common-law at the time of the referral. Donna's father is 14 years older than her mother. Mr. B and the grandmother are approximately the same age.

Mr. B (in his early fifties) was retired from the Armed Forces. He was alcoholic, had been unemployed for approximately a year. He was in poor health. It was suggested by the SCCA Worker that he had cirrhosis of the liver. He took no responsibility in parenting any of his children. When drunk, he became quite violent.

The grandmother (in her mid-fifties) was an ineffective parent. Although well-intentioned, she had no idea how to set limits with any of the children or how to cope with Donna's medical problems. She indicated to the SCCA Worker that she found it easier to blame others regarding the family situation rather than realistically work out the problems.

Donna's older sister was 20 years old. She was apparently quite promiscuous. Donna's older brother was 19 years old. He had been in trouble with the law. Both siblings were out of the house as much as possible to avoid the conflict.

Psychotherapy

Donna was seen for 16 sessions from January, 1977 until the end of May. Each session was approximately 1 hour in length. The first session was held in conjunction with the Director of Youth Service and its focus was that of assessment rather than therapy.

The focus of the next 2 sessions was on developing a relationship with Donna. She had clearly stated that she hated all of the other professionals in her life because they continually confronted her as using a "sick role" to get attention. The student perceived this as a warning from Donna of what not to do if trust were to develop.

A constant theme of Donna's in the first few sessions, was that of her struggle to be as independent as possible. Donna didn't realistically focus on how independent a quadraplegic could ever be, instead blamed her family, physiotherapist and everyone else in her life for being in a dependent state. At the same time as Donna was discussing independence, she repeatedly was late for appointments (she had told the specialized bus driver for "Wheels" that her appointment was half an hour later than scheduled). When asked about why she was late, Donna continually explained that she had forgotten the time. (The sessions lasted only the remaining amount of time and didn't go into the next hour). This issue was dealt with by the student by casually mentioning to Donna that it must be very difficult to become independent when she was so forgetful. Donna was never late again and there were no further problem of that nature. In fact, Donna opened up more fully at this point.

A direct confrontation over the issue of lateness would have only reinforced Donna's view of professionals as being confrontive and uncaring, and would not have served to develop the relationship any further. Donna had no trust in any adults in her life and the alliance that had been

built between therapist and client could not be tampered with.

A reading of Josselyn (1971) helped to make the decision as to how to confront Donna's habitual lateness. She says the following of psychotherapy with adolescence:

> "It requires an ability to be one with the adolescent and thereby experience that which the adolescent is experiencing; skill in recognizing when that identification should cease and a knowledge of how objectively to help the adolescent free himself from or utilize constructively instead of destructively, that which he is experiencing." (p. 130)

Josselyn suggests further that the adolescent needs to feel that the therapist accepts him as a person. Donna's sense of self worth was so fragile, that a direct confrontation would have been perceived as an attack rather than as a supportive stance.

After the fourth session with Donna, the student asked her father and grandmother if they would come for a session. The student felt that it was impossible to help Donna cope with the home situation without ever having met her parents, or without having discussed Donna with them to obtain their perceptions of how she functioned. (When the idea for sesion was mentioned to Donna, she got quite angry and stated that it wouldn't help at all).

Meeting the parents turned out helpful for the student. It served as a chance to learn what happened to Donna at home, and for the therapist to share some perceptions of Donna with the parents. It was clear that neither Donna's father or grandmother had any idea whatsoever of the needs of an adolescent girl, or the needs of someone with Donna's physiological limits. The parents also made it clear that they did not want to be involved in any therapy with Donna. Donna's problems were her problems and there was nothing they could do to help.

The student called a case conference in late March after Donna had been in psychotherapy for approximately two months. All of the other

professionals who were involved with Donna asked to come to the confernce. This included two workers from the SCCA, two teachers from Donna's high school, and a social worker from what was then the Department of Health and Social Development. The purpose of the conference was to inform the other professionals who were working with Donna, what the student was trying to do with Donna in therapy in hope that all would have similar goals when at all possible. The feedback from the people and the conference was that since Donna had started therapy she had improved in school and was behaving more appropriately in group recreation activities at the SCCA.

Donna was not present at the case conference. This was not a deliberate attempt to exclude her from the discussions, but was a chance for all those who were working with Donna to discuss her behavior and make some concrete treatment plans. The plans were all shared with Donna at the next session that the student had with her.

The focus of therapy for the next three months until the end of the practicum was directed at helping Donna cope with her home situation. Each session, Donna would vent anger at her father and grandmother's inconsistency and their uncaring attitude. Through the course of this ventilation, Donna developed much insight into her sick role, the purpose of her fantasies (particularly the fantasy that involved having a baby as soon as possible). She was also able to begin to understand why her family behaved as they did. This further understanding of her family allowed Donna to manage much better at home than she had previously.

The counselling skills that were used were empathy, warmth, genuineness, respect, and concreteness as described by Truax and Carkhuff.

Meeks (1971) suggests:

"It should be emphasized that the primary function of the

> therapeutic alliance with the adolescent is to assist the youngster in understanding the link between his feelings and behavior in the present." (p. 90)

The empathy allowed for the development of the alliance that Meeks suggests.

Keefe (1980) discusses the skill of empathy. His views are particularly interesting in light of the progress made by Donna as a result of the empathy that she received. He states that empathy is useful in fostering positive individual growth, and that empathic skills are an ingredient used by those concerned with individual change. Keefe further points out that the client of a worker utilizing empathy, experiences that he is not alone as he is understood by someone else. The client will then share more about himself as a result of the empathy.

Donna certainly shared more about herself as she felt understood.

Results of Therapy

After therapy, Donna was able to cope at home. She had learned to cope with her parents. She had not had one asthma attack and thus did not require hospitalization.

The most marked area of improvement for Donna was in school. She was attending regularly (5 days per week) where previously it had been two-three days a week. She started to do her academic work, and in fact won two prizes at Awards Day at school. (One was for the most improved student in her class, and the other was for the most improved student in the entire Junior High).

Donna also improved in the area of her physiotherapy, whereas for several years prior she had not progressed at all. She had operations that would enable her to walk, but she hadn't learned because she wasn't motivated. About half way through the therapy, Donna learned how to lift herself in and out of the wheelchair. At the end of the therapy, Donna

was learning to walk and could do so with the help of a walker. The SCCA had made plans for Donna to have a further operation to loosen her limbs. The SCCA were so impressed with Donna's progress that this operation was scheduled when they had said previously that they wouldn't perform it.

Socially, Donna had matured. She had developed relationships with her peers whereas previously she had ridiculed them and kept mainly to herself. Donna's perceptions of the other professionals involved in her case changed as well. They were no longer viewed as uncaring people, but as people who cared and therefore confronted Donna to help her rather than because they were angry at her.

Minuchin states the following:

> "Patients move for 3 reasons. First they are challenged in their perception of their reality. Second they are given alternate possibilities that make sense to them, and third, once they have tried out the alternative transactional patterns, new relationships appear that are self-reinforcing." (p. 119)

The student believes that Donna changed as much as she did, because the student was the first professional ever involved who was totally supportive. The method by which the student confronted Donna was very different from anything that she had previously experienced. She was helped to look at herself supportively, rather than having her personhood attacked as was her previous sense of confrontation. Donna responded well to empathy, warmth and unconditional positive regard.

B) FAMILY THERAPY

2. Colleen and her Family

Colleen was a 16 year old female. She was the second of five children.

Colleen's mother, Mrs. B, telephoned Youth Service in February, 1977 and asked if her daughter could receive psychiatric help. Mrs. B was concerned because Colleen had just quit grade 10 for the second time, and had also quit a job that her parents had found for her. Mrs. B stated that Colleen was quite disobedient, and that she never showed any remorse. Colleen had agreed that she would see someone, but only to prove to her parents that she wasn't crazy.

There was a total of 19 contacts made with this family. Colleen was seen alone 8 times. The parents were seen by themselves 4 times. There were 4 conjoint interviews between Colleen and her parents and 3 interviews with the entire family.

Family History

Mr. and Mrs. B had been married for just over 20 years. They had moved to Winnipeg from Vancouver 6 years prior to the therapy. At that time they had separated briefly. Mr. B was quite depressed at the time of the separation was going through what his wife termed "male menopause". During that separation, Colleen was used as a "pawn" by her father. The parents soon re-united, and went through a "second honeymoon". They sent Colleen to a child psychiatrist at the time because they felt she showed no emotion.

Both parents came from families where feelings and emotions were never discussed. This norm was brought into their marriage and was quite dysfunctional. Mr. B was very intellectual and rationalized most of his behavior. Mrs. B was able to express feelings slightly more. She

was often angry, but smiled at the person she was most angry at, while telling them that she wasn't angry.

Colleen was the only one of the 5 children who was planned and really wanted. However, her mother stated that "even as an infant, Colleen could never be satisfied." Colleen would cry until she was ready to stop, and no one could pacify her.

Colleen was the only child who had difficulty with the adjustments of the move from Vancouver. Her parents analysis of this was that the move took place when Colleen was in grade 6. All of the girls that she was in school with and could have been friends with, were in established relationships that had been formed in grade 1 or 2 and they didn't make any room in their relationships for Colleen. Colleen was never able to make friends.

Colleen was an example of the one of the five "types" of girls described by Cohen-Kovar. She was clearly an "anarchic bohemian". Colleen's difficulties were often spoken of historically by her parents as is described by Cohen-Kovar.

Colleen was a beautiful girl. (The whole family was very attractive). She was, however, withdrawn and sullen. She seemed to have learned the family norm of not expressing feelings. She never discussed feelings, her voice tone seldom changed, and she had a great deal of difficulty maintaining any eye contact when talking. Colleen's values were compatible with those descriptions by Cohen-Kovar. She loved Buddism, and was overly concerned about the lack of opportunity for the American Indian. School and work bored her. She would much rather write poetry, draw, or smoke marijuana. Colleen had few, if any, female friends, but attracted many males as she was so pretty. These relationships were always of short duration due to Colleen's aloofness and fear of closeness. However, Colleen

was an intelligent, well-read girl.

Family Therapy

The initial interview was with Colleen alone for the purpose of assessment according to Youth Service procedures. Mrs. B was also seen early in the assessment process in order that more information could be obtained about Colleen.

During this initial assessment period, Mr. and Mrs. B went out of town for a holiday. While they were gone, Colleen stole one of the family cars and started to drive to Vancouver. She got as far as Alberta where she had a bad accident and smashed the car beyond repair. This incident isolated Colleen even further from her family. Colleen expressed no remorse at destroying the car. Her only concern was that she had asked the wrong girl to go with her on the trip.

While being assessed, Colleen compared her father to Jesus Christ. "He's nice, but lots of jerks get in his way". She did not speak this way about her mother.

She spoke of wondering whether she was crazy or not. The reason for This self doubt began at school, when the other students would always stop talking as soon as she entered the room.

Mr. and Mrs. B were seen once alone prior to conjoint family sessions. They kept the focus of the session on Colleen and her behavior. There was some slight hostility between the parents regarding Colleen. Mrs. B felt that Colleen could always easily manipulate Mr. B. He denied that and became defensive and intellectual.

The following quote by Minuchin seems indicative of the B family's perceptions of Colleen and is interesting because it discusses their approach clearly:

"The family's approach to their problem is usually oriented

> to the individual and to the past. The family is brought into therapy by that deviance or pain of one member, the identified patient. They want the therapist to change the situation without changing their preferred transactional patterns. In effect, the family is asking for a return to the situation as it was before the symptoms of the identified patient became unmanageable." (p. 120)

The first session with the entire family was held in early March, about four weeks after the first contact with the family was made. The majority of the family members were united with the parents against Colleen. All of the other children perceived Colleen as the problem. She did have some support from a 14 year old brother and a 10 year old sister. The 19 year old brother and a 12 year old sister were clearly as blaming of Colleen as were the parents. This brother was quite parental and the sister seemed to compete with Colleen.

Goals, for what the family wanted changed, were very difficult to establish. The family took a blaming stance against Colleen and the student was unable to re-define the problem as a system problem. Two of the siblings were reluctant to return for any further family sessions as they felt that nothing would help. The entire family did agree to another session.

The second session focused on the communication and transactional patterns that emerged in the family. The student taught a brief overview of Transactional Analysis Theory* (Harris, 1973) with a focus on Parent, Adult and Child, in order that the family would have common language with the therapist from which family patterns could be discussed.

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* A Note to the Reader

The student acknowledges at this point that although Transactional Analysis Theory was not discussed in the literature review, it was a treatment intervention used with the B. family. As social work practise is so varied, there is a need for all workers to have a broad repetoire of interventive strategies that can be used as needed appropriate to the specific case and situation. Transactional analysis is this type of intervention - used when needed, taken from a repetoire of strategies.

The following is a description of what was taught and the B family typical patterns:

Parent-
Nurturing
Influencing

- The family was taught that every person had the 3 components of their personality (Parent, Adult, Child):

Adult

- They were taught the characteristics of the nurturing parent-warm, caring, taking care of others. The influencing parent-musts, shoulds giving orders, punitive.

Child-
Rebellious
Spontaneous

- The adult-rational part of the personal.

- The spontaneous child warm, fun, loving, natural. The rebellious child angry, pouting, punishing.

- The family was taught how certain ego state comments illicit responses to the person being spoken to by the tone of the message. For example, when someone is spoken to from an influencing parent - where many shoulds or musts have been given, then the receiver of the message tends to respond in anger from their child ego state.

- A rational adult message tends to illicit a rational adult like response. The B family was also taught how certain transactional patterns often develop over time withouth the people being aware of the patterns.

Colleen and Mrs. B

Mrs. B always spoke to Colleen from an influencing parent stance. Colleen felt put down and her rebellious child responded to her mother, and this resulted in Colleen putting her mother down. This pattern would continue with each speaking to each other from a different ego state, with nothing ever getting discussed in a beneficial way.

Two of the younger children demonstrated this pattern perfectly. They duplicated the traps that Mrs. B and Colleen repeatedly fell into.

Colleen and Mr. B

Mr. B was an extremely rational man. He spoke mainly from his adult ego state, never utilizing feelings, only reason. This appealed to Colleen because she would respond from her adult ego state. Their communication

problems would arise because Colleen didn't accept much of what her father offered. At that point, father would get angry and speak to Colleen as an influencing parent and the pattern would be similar to Mrs. B and Colleen.

Colleen and Siblings

The communication patterns between Colleen and her brothers and sisters was more varied, and the children were able to demonstrate more care for Colleen than were the parents. (They are not discussed because they are too numerous to include).

Siblings and Parents

Mr. and Mrs. B used similar transactional patterns with the other children as they did with Colleen. The major difference was that both parents were able to be "nurturing parents" with the other children - demonstrating their love and warmth. These behaviors were never shown to Colleen.

All of the family except Colleen understood the Transactional Analysis Theory and examples and saw how it applied in their family. It was difficult to determine why Colleen didn't understand. The student speculated it was because Colleen would then be allied with the family in one area, and then the whole balance between the family members would be destroyed. Colleen also used the defense of denial as her primary way of coping. Understanding the Transactional Analysis Theory could have been too threatening. A person who uses denial requires more support.

The student suggest to the family, that for further therapy, the family might do better by being split up. The suggestion was to see Colleen more, the parents alone, and Colleen and the parents together, with periodic whole family meetings. The family readily agreed to this. Minuching was referred to for the above decision. He discusses reasons

for separating the family:

> "With some families the therapist always works with the total group. In others he selects the group he feels is most appropriate, alternating different groupings depending on the developing dynamics. In general, the therapist should protect the spouses' privacy from intrusion. When working with families with adolescent children, the therapist can hold individual sessions with each adolescent, which allows for exploring issues autonomously and for establishing a relationship with a significant extra familial adult that would not be possible with the total family group." (p. 135)

The next 6 sessions were held with family subsystems. Colleen was seen alone 4 times and the parents alone for the remaining two times. The parents continued to voice their frustration with Colleen, and took little ownership of the problem with Colleen. They perceived themselves as responding to her misbehavior, and that they had no choice but to respond in the way they had been. Mrs. B did acknowledge that some of her behavior did serve to isolate Colleen further. (eg. - Listening in to Colleen's phone conversations).

Colleen showed little progress. She was still highly defensive and denied responsibility for her actions, saying that there was nothing wrong with anything she did. She spoke little in the sessions, when she did there was minimal eye contact, and she smiled inappropriately. She was frequently late, and one session, Colleen came in after having smoked a great deal of marijuana. She was sent home immediately after it was pointed out that being stoned was not the most appropriate way to work.

A blow up at home, which was quite a crisis for the family, motivated them to change their ways of interacting with each other. The crisis had started out an an argument, but Colleen threw things around and was then hit by her father.

The B family was involved, angry and upset. In crisis the father was not his overly rational self. This family was finally ready to change.

The student worked out a negotiation plan with the family. The parents gave in to some of Colleen's demands around money and times to be home. Colleen said that she would attend school and that she would be more courteous to her parents.

Mrs. B was furious with Colleen, and wasn't able to negotiate. She perceived Mr. B as giving in to Colleen rather than negotiating a way for their family life to be more comfortable. She had not been the one to hit Colleen and wasn't as moved by the incident. She was not able to deal with her anger.

The crisis was somewhat of a turning point for Colleen. After that for the next month she was able to open up more, and trust the student somewhat. She spoke up more in the sessions. Colleen said she was beginning to understand her parents more, and understood why they responded the way they did to her "misbehavior", and her disobeying their rules. She said that she was also prepared to accept the consequences her parents gave out of her behavior.

Approximately 6 weeks after the crisis, in a joint session with the father and Colleen, Mr. B said that things at home had only slightly improved. Colleen was devastated by that moment, and felt like giving up. She had perceived herslef as having changed greatly, and her parents had seen only minimal growth.

After three and one half months of therapy, the student terminated with the family due to the end of the practicum. They chose not to be transferred to another worker. The last session was held with the entire family in their home. Colleen was functioning in a slightly better way according to the rest of the family. There were no longer regular arguments between Colleen and her parents, and Colleen no longer absented herself from the family on weekends when she was grounded. The family

seemed to have adjusted to each other, and become somewhat more accepting of each other. Nothing had changed, however, in the family's perception of Colleen as the identified patient.

The student views this family therapy as not having been successful. The family's perceptions of Colleen and of the family relationships did not change. They all seemed to grow tired of fighting.

In retrospect, if the student could see this family again, the following changes in therapy would be made:

1) Work would have been done with the parents on their relationship. The role that Colleen played between them was never clearly established. At the time of therapy the student found it difficult to confront the parents on their perceptions of the problem. This would have been done more consistently. The parents would also be shown how Colleen's communication patterns duplicated their own.
2) Directives as described by Haley (1976) would be given out to Colleen and the parents. A prime directive would have focused on the development of positive interactions between Colleen and Mrs. B.
3) Finally, an intervention would have been developed for the entire family to change their perception of the problem from Colleen to an entire family system problem. Thus, the siblings and parents would have been more motivated to work at making their home life more pleasant.

B) FAMILY THERAPY

3. Tony and his Family

One male adolescent and his family were seen in order that the student would have the opportunity to contrast this situation with those of adolescent females and their families.

Tony was a 15 year old Metis boy who had been adopted by caucasian parents.

In December of 1976, Tony had been suspended from his school due to the destructive behavior he had exhibited there. He had also been drinking and staying out all night; and had been frightening his mother by being violent on purpose. Mr. and Mrs. M were quite upset and frustrated by Tony's behavior and had asked a friend of the family (who was involved in the Juvenile Justice System) what they should do about Tony. This person referred the family to Youth Service.

There were a total of 16 sessions with the M family. Most were with the parents and Tony. One session included an older married son. Tony refused to come to three of the sessions so they were held with the parents alone. Contact was between December, 1976, until the end of May, 1977.

Family History

At three years of age, Tony had gone to live with the M family as a foster child. He had been in the care of Children's Aid of Winnipeg since he was 2½ months old. The two natural M children were teenagers at the time. Mrs. M wanted to do something "worthwhile" with her free time and decided to take in a foster child. Shortly after Tony had come to live with the M family, they began adoption procedures.

The difficulties with Tony had begun shortly prior to treatment. He had always had trouble with school work due to eye problem, but had never been destructive or violent prior to September of 1976.

The problems in the M family seemed to begin shortly after Tony entered adolescence. This was an example of a developmental crisis that was not dealt with by the family in the most appropriate way, and eventually became a situational crisis that demanded resolution.

The following quote by Minuchin is interesting in the context of the M family problem:

> "One of the most common precipitatas (of stress at transitional points in the family) is the emergence of a child into adolescence. At that time, the child's participation in the extra familial world and his status in that world increase. The relationship between child and parent is dislocated. The adolescent should be moved a little away from the sibling subsystem and given increased autonomy and responsibility appropriate to his age. The parental subsystems transactions with him should change from parents-child to parents-young adult. The result will be a successful adaptation.
>
> However, the mother may resist any change in her relationship with the adolescent because it would require a change in her relationship to her husband. She may attack the adolescent and undermine his autonomy instead of changing her own attitude." (p. 64)

Mrs. M clearly blocked Tony's development of autonomy.

The two natural M children did not have the same difficulty with their parents at adolescence as did Tony.

Family Therapy

At the point when the M family came for help, the family was quite dysfunctional. Tony was out of school and was going to work daily with his father so that "he doesn't have a good time at home" and primarily because he was frightening his mother by being violent. Mrs. M was totally unable to set any limits or controls on Tony. On two occasions, after Tony had frightened his mother, Mr. M and Tony had fist fights. Father was quite ashamed that they had reached that low a point in their relationship.

A salient point that influenced the course of the family therapy was

that Tony had admitted to Youth Service as a full-time patient. This individual psychotherapy, as well as the entire Youth Service program had a marked influence on Tony, and thus on his parents and the family sessions. (This will be dealt with more fully in Chapter 3.)

In the first session with the family, it was clear how frustrated Mr. and Mrs. M were with Tony. They were questioning their ability as parents, but saw Tony as the only one who needed to change. They had stated that all of this stress had brought them closer together.

Tony was as frustrated with his parents as they were with him. He said that he felt caught between his parents and his friends. He was unable and unwilling to open up at all about what he was feeling. He was able, however, to direct anger at his mother.

Mrs. M was unable to admit directly that she was angry at Tony, although her voice and her non-verbal behavior clearly indicated the anger.

Mr. M seemed to be the strength in the family. He was able to speak directly about his feelings, thoughts and frustrations.

In the second family session, the parents and Tony started to discuss the things that they would like to be different around the house. A contract was established between Tony and his parents regarding who would do that. Mostly household chores were discussed as these were the conflict areas. Tony was again unable to speak about what he would like to be different in the home. It became quite clear the difficulty that Mrs. M was having was letting Tony grow up. She wanted him in bed early, didn't want him to be alone in the house and wouldn't give him his own house key and insisted on paretnal management of his money.

Williams (1975) stated:

"At no time in a woman's life is her own identity more

> threatened than at the point wher her maternal role must give way in light of her last child's adolescent maturity ... Mothers at such points of personal crisis may unwittinly hold on to their teenage sons and daughters stifling their psychosocial growth."

This quote seems to be consistent with the way that Mrs. M was treating Tony.

The student began to discuss with the parents the developmental needs of an adolescent boy. Minuchin describes that process as follows:

> A therapist should know the developmental needs of children and be able to support the child's right to autonomy without minimizing the parents' rights ... At times, the therapist must act as a translator, interpreting the children's world to the parents or vice versa." (p. 59 - 60)

Mrs. M began to understand that at fifteen, Tony wasn't a child any longer but was a young adult.

The third session continued to focus on the developmental needs of an adolescent, particularly the need of autonomy. Focus was also on the communication patterns between the family. In a role reversal, where Tony was Mrs. M, he duplicated her communication style quite accurately. Her response was "I'm not like that at all."

Tony opened up slightly in this session by saying that he felt isolated at home, that his parents were always against him. Tony's statement was a true reflection of the family alliances.

The family was given the task of going cross-country skiing together. This was never done. At this point, the family functioning started to deteriorate. Tony had become angry at his mother for what he perceived as nagging. He pushed her quite a bit until she became angry and frightened. Tony admitted that he frequently set up situations where his mother would reject him and he thus was reinforced for feeling badly about himself.

Tony seemed to control his parents by "pushing buttons and pulling strings", until he received the response he wanted.

Another issue arose that caused great difficulty for Mrs. M was Tony's attempt to become more "native". The two other native adolescents receiving care from the Youth Service became Tony's only friends. He started to wear his hair much longer, and generally started to look "Indian". Mrs. M seemed to be somewhat prejudiced against Indians and had trouble accepting the fact that her son needed to explore his native roots. Long hair seemed to reflect a "Main Street mentality" to Mrs. M. She refused to discuss the choice of Tony's friends at Youth Service.

Frequently before the family sessions were scheduled to begin, Mr. and Mrs. M came in early to discuss Tony's behavior with the student. In hindsight, the student now believes how seeing the parents without Tony (when he knew they were with the student) could have only served to further separate Tony from his parents. It would have been easy for Tony to perceive the therapist allying with his parents against him.

In further family sessions, Tony refused to, or was unable to, co-operate. He wouldn't sit still, had to play with something and seemed generally very uncomfortable. The student attempted to give him non-threatening opportunities in which to express himself but he was unable to talk.

The student was trying to shift the focus of the family sessions from Tony to the family process and interactions. Minuchin discusses how this can be done and why it is appropriate:

> "The family therapist broadens the focus of the problem to include family interactions and in most cases some aspects of the family interactions will become targets of the therapy. Consequently, the family and the therapist must come to an agreement on the nature of the problem and on the goals for change." (p. 132)

This broadening of the focus of the problem was very difficult to do with the M family. The parents were beginning to see that some of the ways in which they responded to Tony served only to reinforce his acting

out. However, they still tended to blame Tony for problems and gave him very little positive reinforcement or "stroking" when he needed it.

When Tony was asked what he wanted different in the family, he said that he wanted to live alone. He tended to ask for unrealistic requests, in order to be turned down, and therefore he would have a reason to act out. Tony's request to live alone could also be a reflection of the influence that the other adolescents on Youth Service were having on him. The majority of the others lived in group homes where the controls were considerably lighter than what Tony was experiencing at home. Group homes seemed more glamourous to Tony than living at home.

The issue of Tony's leaving home was one that the student was unable to resolve with the family. The issue first surfaced (when Tony said he wanted to live alone) in early February and continued until May. Tony seemed to have decided that his goal was to leave home so that he was not prepared to work in the family sessions, and he continued to act out violently at home (broke the fence, broke a stereo, scared Mrs. M with a knife, etc.), in order that he could get his parents to reject him completely.

From the beginning of March until the end of May, Mr. and Mrs. M couldn't decide whether they should let Tony leave home and be placed elsewhere. The student interpreted Tony's behavior to the M's with a focus on how Tony was testing them and seeking further rejection which would reinforce an already poor self-concept.

Mr. and Mrs. M seemed to understand the reasons for Tony's behavior, but that knowledge did not give them the skills they felt they required for working with Tony. They had previously told Tony that if he wanted to, he could be placed outside of their home. However, after re-thinking the situation, they decided that they were not prepared to have Tony leave

home. Tony responded by having a huge blow-up, where he totally lost control.

Youth Service had Tony placed temporarily on PI 3 - the locked psychiatric ward at Health Sciences Centre. This was an attempt at stablizing his behavior.

The parents' response to this blow-up and hospitalization was to say that if Tony wanted to leave he could. They expressed much ambivalence over saying he could leave, however, they were not sleeping or eating properly and felt their own health needed looking after. They said that if Tony changed his mind in a few months and wanted to renegotiate living at home, that they were prepared to do that.

Tony stayed on PI 3 for approximately 1 week. After he was released, he returned home. Mr. M was prepared to work at the relationship with Tony, however, Mrs. M was unprepared and unable to move. She rationalized all of her dysfunctional parenting behavior by saying "I've always done it that way". She became very resentful of the student's interventions which were directed at explaining and demonstrating the impact that her verbal and non-verbal behavior had on Tony, and on learning new ways of responding to Tony.

In April, Tony received a one-week suspension from the Youth Service program due to his lack of involvement in any area of the program. He did not tell his parents of the suspension, but left the home and pretended to go daily. This episode served to isolate Tony even further from the family. His parents felt that he had not taken full advantage of the latest chance available to him. All of the trust between parents and son had now been completely eroded.

During the latter part of April and May, nothing changed in the M family. The only way the family managed to not fight was to avoid dis-

cussing anything. The parents had lost all hope of things getting better, no interventions that the student made could get the family to do any work. Tony refused to take part in any family activities. He became generally more unco-operative and was suspended a second time from Youth Service. Mr. and Mrs. M had phone Children's Aid of Winnipeg and had requested to have their son placed.

Termination with the family took place shortly after. The involvement of Children's Aid (who were reluctant to place Tony) seemed to dissipate all the anger of everyone involved. Tony knew he was leaving home soon, and his parents stopped all attempts at control. The family were given the opportunity to work through the separation with other therapist, but they chose not to utilize that opportunity.

Results and After-Thoughts

It is very difficult for the student to determine whether this total family intervention was successful or not. One tends to judge success on the basis of whether the family remained together and solved their difficulties. In the case of the M family, if that measure of success is to be used, then the therapy was certainly not successful. The student believes, however, that other factors have to be acknowledged to this situation. Tony decided very early in the therapy that he didn't want to live at home and accordingly behaved in ways that would accomplish his goal. Therefore it was difficult to keep this family together.

Tony's desire to leave home seemed to be a combination of the following factors:

1) Mrs. M's inability to let Tony grow up;

2) Mr. and Mrs. M's lack of awareness of the importance of Tony's identifying with Native people;

3) Tony's belief that his parents would never change.

The therapist tried to see Tony alone to ally with him somewhat and find out what he believed. He would never allow that to happen.

An issue about which the student could have dealt with Mr. and Mrs. M was their commitment to Tony. It was never established whether the commitment to their adopted son was less than the commitment to their natural children, although at times it seemed so.

Another issue that the student could have dealt more fully with Mr. and Mrs. M was their reluctance to let Tony grow up. Tony had been adopted when the other M children were in their teens. As mentioned earlier, Mrs. M had wanted something to do with her time. Possibly Tony's adolescence and his strive for autonomy indicated to Mrs. M that she no longer needed to the same extent in her role as mother. The only way to deal with the need to be mother was to keep Tony a child.

The last issue that also could have been dealt with more fully was Mr. and Mrs. M's relationship. Mr. M was very protective of Mrs. M and would never leave her alone with Tony. Mr. and Mrs. M seldom left the house together because they were afraid to leave Tony alone. They thought that he might destroy more things in the house. The parents had stated that the difficulties with Tony had brought them closer together. The nature of that closeness however was difficult to determine.

Another salient factor that influenced the outcome of the family therapy was Tony's involvement in the Youth Service Program. This will be dealt with in Chapter 3.

The student met Tony several times in the three years after the family therapy had terminated. Tony had been placed at Hugh John MacDonald Hostel over the summer of 1977. He visited his parents occasionally on weekends and said that their relationship "was O.K.". After he left home, Tony became delinquent and had become involved with the law on marijuana related issues. Once he turned 18, however, Tony's involvement with the law ended.

CHAPTER 3

FAMILY THERAPY SIMULTANEOUS WITH ONE MEMBER RECEIVING INDIVIDUAL PSYCHOTHERAPY AND INTENSIVE TREATMENT

The M family was the only situation where the student had the opportunity to observe what happens to a family when one member receives intensive treatment and psychotherapy in addition to receiving family therapy with the remainder of the family.

Tony's experience at Youth Service had much impact on him and on his parents. In the B family, Colleen was not receiving any treatment other than with the family therapist. In the case of Donna B, the family received no treatment. Therefore, the change in family dynamics, to be described in the M family was not seen in the other cases because the situation regarding the manner in which treatment was given, differed.

The impact that the Youth Service program had on Tony and his parents was great. This impact certainly was not all positive, and the student questions whether some of the new family dynamics and problem that arose after exposure to Youth Service needed to occur at all.

At the point that the M family was being seen by the student, Tony was a full-time patient on Youth Service and was receiving psychotherapy from a psychology intern. Tony was also partaking in(or merely being exposed to as he chose) the entire Youth Service Program which was full days Monday - Friday, and two evenings a week.

The student stated earlier in the report her belief in the necessity of providing family treatment to both the adolescent and the family as both have been affected by the issues of the adolescence. In the case of the M family, the way in which parents and son dealt with adolescent identity gave rise to some serious interactional and communication problems. Therefore, both parents and son required family therapy to work through their differences and problem areas.

The nature of the Youth Service Program and the way in which Tony responded to it, seemed to detract from the effectiveness of the family therapy. The program, due to its comprehensive nature, tended to take over control of Tony and his life. There was little structure that he set for himself - he spent the majority of his time at Youth Service, and didn't become independent in any way. Tony was hospitalized as an inpatient when his behavior became violent; he was then given tranquillizers to slow him down. The program became the central force and control in Tony's life.

It appeared that Tony began to behave in the role of a psychiatric patient. He seemed to become more "sick" and "disturbed" after his treatment had begun than he appeared prior to treatment beginning, or during the initial phase of treatment. This phenomenon of becoming "sicker" is similar to the process of children adapting to placement in a residential group home or institution. Initially, at placement, the child behaves very well, as if in a honeymoon phase. At the point that the child becomes comfortable in the setting his behavior tends to deteriorate until the "real" child is seen. (This was witnessed and experienced by the writer through eight years of working with children and adolescents in residential care). The same process may have happened to Tony. That is, when he became more comfortable at Youth Service, he was able to express himself as he truly needed to, that he was as disturbed as his behavior said.

As Tony's behavior became more dysfunctional at Youth Service, it also became more dysfunctional at home. His parents then became increasingly more frightened of him, and more frustrated with him. This reinforced their feelings of being inadequate in dealing with him. The hospitalization and the implication that Tony couldn't control himself certainly led his parents to feel totally inadequate. It seemed to them that the Youth Service couldn't control Tony either.

Another problem that occurred in the M family after Tony became a Youth Service patient was Tony's desire to leave home. This had never been discussed as an alternative for the M's prior to Tony coming into contact with other adolescents who had dealt with their family problems by leaving home. This became an easy solution for Tony. If Tony had heard about group homes prior to his Youth Service experience, he had not viewed them as places where the residents could do almost all that they wanted to, where the rules were much more flexible than the ones he was accustomed to at home. After exposure to children living in group homes, Tony decided that he must live in one.

Another experience that Tony had as a result of Youth Service, was his brief placement on the locked psychiatric Ward PI3. This had frightened Tony. His roommate was an extremely violent ex-Stony Mountain convict who spoke of his past "escapades". The other patients all were obviously disturbed. It would have been natural for Tony to compare himself with the others on the ward, most of whom were heavily sedated due to severe psychiatric disturbances. When comparing himself with those patients, and observing the need for himself to be locked up, Tony would certainly start to wonder whether he was as disturbed as the other patients that he saw on PI3. After his placement on PI3, it was difficult to determine many positive changes in Tony's behavior.

Tony was receiving individual psychotherapy two-three times weekly. This was not at all at cross-purposes with the family therapy, as Tony's self-awareness was greatly increased. He was, however, encouraged to express his anger at his parents which he did by breaking the fackyard fence and threatening his mother with a knife. This type of expression of anger made it difficult for the parents to trust their son.

Some of the peers that Tony associated with at Youth Service were far

more emotionally disturbed than he was. His two closest Youth Service friends were both quite suicidal, as were other adolescents on the program. Those adolescents behaved in ways that were consistent with their disturbances. These adolescents formed Tony's peer group and reference group. Disturbed behavior was the norm rather than the exception. After exposure to these disturbed adolescents, Tony's behavior became more disturbed.

The student has to question what would have happened to Tony and his family if he had not become a full-time patient on Youth Service. The student wonders whether the outcome of family therapy would have been more successful if Tony had received family therapy and individual psychotherapy at the Service on an out-patient basis, and had been enrolled in another public school.

If Tony had been enrolled in the public school system, even in an open program such as Argyle School, he would have been exposed to peers who behaved in more socially acceptable ways, and he might not have become as dysfunctional as he did.

The student is aware that these are speculations and not necessarily facts. They are, however, questions that arose when working with the M family, and questions to which there are probably not any answers.

The student believes that Tony and his parents might have progressed further in treatment if Tony had not been a full time patient on Youth Service, but instead a part-time out-patient receiving individual psychotherapy and family therapy. The student, however, was not the therapist who initially interviewed and assessed Tony, nor did she regularly provide treatment to him on an individual basis over an extended period of time. It is possible that she didn't see the true nature of Tony's difficulties by observing him on the program and in the family sessions. There is no intent here to either question the decision making process on the person who decided to

admit Tony to Youth Service on a full-time basis, but rather to point out the iatrogenic effects that the treatment had on Tony.

The underlying supposition of this chapter is that Tony would have worked harder in the family therapy if he had not had several professionals and therapies involved with him. If the family therapist had been the only professional that Tony had to work with, there may have been more incentive for him to work. The structure of Youth Service was that there was an expectation to work in individual therapy, in group therapy as well as occupational therapy and academic school work. Tony also had the family therapy. He may not have had the necessary emotional or psychic energy left over to work in the family therapy, whereas if the family therapy had been only therapy (or even if it were accompanied by out-patient psychotherapy, as in the case of Colleen B), Tony would have felt the need to work harder in the family sessions, as they would have been the prime source of support for him.

Family therapy was not the norm for the other Youth Service patients, there was no peer pressure for successful family therapy, indeed quite the opposite.

As explained, the impact the Youth Service Program had on Tony was strong. As Tony changed, based on his new peer group, new system of friends and new learnings, he carried those changes with him into his family system. The outcome of the family therapy, and in fact the course of the therapy was affected by the negative ways in which Tony started to behave after his exposure to Youth Service. If that exposure had not happened, it is possible that family therapy could have been more beneficial to the M family.

It is important to mention at this point, that the student does not believe that in order for family therapy to be successful, that all family members have to limit their exposure to outside stimuli. Quite the contrary. In the case of the M family, it seemed that the Youth Service exposure was in some ways an experience that was unnecessary to the treatment of this family.

CHAPTER 4 - CONCLUSIONS

ISSUES THAT AROSE WHEN WORKING WITH FAMILIES CONTAINING ADOLESCENTS

Working with families containing adolescents is difficult yet stimulating work. Several issues that posed therapeutic challenges for the student arose in all of the families that were worked with in the practicum. These issues were difficult to deal with yet contained important issues for the therapist to consider..

Three of these issues or therapeutic challenges will be discussed as part of the conclusions.

The first therapeutic challenge to be discussed was one of the first that the student was faced with (as would be any therapist working with families containing adolescents). This was the way in which both the family and the adolescent dealt with the adolescent's need to separate from parents and childhood relationships. As discussed in the literature review on adolescence, separation from family is one of the critical developmental issues that all adolescents must come to terms with. So must their parents. In the families that were seen during the practicum, there was a tendency for the family to say to the adolescent who was expressing individuality "Go now, leave the family now, you're almost eighteen anyway, and you'll be leaving shortly, you might as well go now and save us more pain". The parents were encouraging the adolescent to leave home as a way of avoiding painful work. Both parents and adolescents were ill-equiped to handle all of the feelings that arose as a result of the adolescent maturing and needing to become self-sufficient.

When children leave home in the way that was described above, the adolescent loses a significant resource for support in their family. Often this type of leaving home could lead to much unfinished business between parents and child. This normal developmental crisis of separation needs to be done in a non-pathological way - and to help the family do this is the challenge for the therapist.

A therapist could facilitate the separation and help the parents and child to learn new identities and roles while still maintaining much needed family ties. The parents tend to feel not needed anymore when their adolescent leaves home. The therapist could teach the parents about their new role and help them to see an added function of parents - that of adviser to a young adult rather than controller of a child. The parents would no longer feel as if a major part of their role as parents was gone, and they wouldn't be in the midst of their own identity crisis.

Both subsystems of parents and child need support in order to work through adolescent separation successfully. The therapist would need to maintain a delicate balance between the two subsystems that needed help, ensuring that the concerns of both were equally heard and equally dealt with allowing the adolescent to leave home with the support of his parents rather than their anger and resentment.

Maintaining the balance between parent and child leads to a second issue or therapeutic challenge - that of keeping the negotiations between parent and adolescent on a mature level. Prior to being able to begin any work with the families seen in the practicum, the student had to negotiate "living together" conditions for the adolescent and parents. The family interaction had deteriorated to such an extent that parents and adolescent paralleled two warring factions that needed a peace treaty to be negotiated before they could live side by side. The issue at the centre of all of this was power and how it was used.

In an attempt to maintain themselves in a power position over their children, the parents started to behave in child-like ways. They seemed to subscribe to the belief of "an eye for an eye, and a tooth for a tooth". The adolescent was continually paid back for his/her misbehavior as it was perceived by parents. The parents in all of the families that were worked

with in the practicum seemed to have lost their maturity. They were unable to understand why their child needed to express independence, but saw this expression as a clear challenge to their authority.

The therapeutic challenge in this stage of family therapy is for the therapist to help support parents as adults and help them to see clarity in their adult role, rather than allowing the parents to behave as children and take part in primitive negotiations. If both parents and adolescent are taught mature ways of negotiating rather than their child-like "eye for an eye", then family relationships can take on a new form with both sides viewing each other supportively rather than as the enemy that needs to be conquered.

A third issue that would be interesting for a therapist to focus on is that of considering how the parents were parented that is, how did their parenting affect how they raised their own children. In three of the five cases with which the student worked, the parents referred to inappropriate role models or no role models for themselves as parents. They felt that this had made it difficult for them to display positive parenting skills as they had never had the opportunity to learn how to adequately parent. These parents had been affected by the style of parenting that they had experienced as children, and it wasn't until their own children were adolescents that they realized they lacked adequate parenting skills.

When therapeutic intervention is provided to the adolescent, has the cycle of poor or inadequate parenting been broken? The answer seems to depend upon how pathological the parenting was, and how successful the therapist was in working through the issues of adolescence and other problem areas with the family.

These three issues posed therapeutic challenges to the student, and would pose a challenge to anyone who works with families that contain

adolescents. If the therapist rose to the challenge and (i) dealt positively with the issues of teaching new roles to parents and adolescents at separation, (ii) structured mature adult-like negotiating and (iii) taught positive, parenting skills and styles, then the chance that family therapy would be successful would be greatly improved.

CONCLUSIONS OF THE PRACTICUM ITSELF

The student felt that the objective of her practicum were met. She developed family therapy skills and the skills to perform individual psychotherapy. The literature in the area of adolescence, adolescent females and family therapy was explored and also highlighted by the practical experience. The student was given the opportunity to work in a setting with a discipline that had a different approach to adolescence than did the student. Although the student often found this difficult, it was an excellent learning opportunity. The student also learned to criticially evaluate theories, perspectives and approaches to treatment.

The student learned to work within alternative perspectives and to "try on" new skills. The student was also faced with, and had to come to terms with, agency politics. The student had to decide whether to openly question another approach at the risk of angering others and being isolated, or to work within the designed structure and value system, intervening only when the student's own clients were involved. The latter option was the one that was chosen and that certainly taught the student patience. Last, working in a psychiatric setting, forced the student to further develop social work values and a strong social work professional identity.

The student had long been interested in working with families, and the practicum experienced was designed to allow that to happen. The work with families did not always progress as the literature suggested but that encouraged the student to work harder and be more creative in her interventions.

In fact, the family therapy in general, was not as successful as the student would have liked. She learned, however, how complex and varied family therapy skills are, and how these skills can not be learned through a review of the literature or through working with a few families. These are skills that take much time and experience to perfect.

From the practicum experience, the student had the opportunity to conduct individual psychotherapy. The skills learned here were immeasurable - these were taught by the clinical supervision that was given to the student, and learned through the practice itself.

The student believes that the practicum was a success as much knowledge was gained and many skills were developed.

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